

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: AR

APPLICATION YEAR: 2006

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

All assurances and certifications are kept on file in the Statewide Services Business Unit, located in the Arkansas Department of Health's State Office in Little Rock.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

In accordance with the Guidance for the 2006 Title V Maternal and Child Health MCH Block Grant Application, the first of two public hearings was held Friday, June 17, 2005 at the Division of Health auditorium. There were 12 people in attendance with Dr. Richard Nugent conducting the hearing. The primary concern expressed at the hearing came from the Parents representative who shared that the recent reorganization of the former Department of Human Services had moved the CSHCN program from the Division of Medical Services (Medicaid) to the Division of Developmental Disabilities. In so doing, the CSHCN case management nurses located throughout the state were being asked to take on an additional caseload of developmentally disabled children who were not experiencing the medical complications and requiring the multicisciplined services common among children for whom the CSHCN services were formerly reserved. This difficulty was made worse by recent cutbacks in other reimbursement programs through tightening up medical eligibility rules in Medicaid, TEFRA and SSI. Dr. Nugent will serve on a new planning team to coordinate children's programs in the DHHS, and will carry this concern to those planners. These problems will be shared with the CSHCN Partnership this year. The second and follow-up public hearing is scheduled for November 29, 2005 at which time copies of this document will be shared and discussed. The plan for these partnerships has been presented to the DHHS.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

1. The broader health delivery system

The entire Arkansas state population, about 2.7 million people, resides in a region of 75 counties. The city of Little Rock, the state's largest, is situated approximately in the middle of the state, and is the site for 6 large hospitals, the University of Arkansas for Medical Sciences (the medical school), the Department of Health and Human Services, and other state agencies relating to the health of children. Cities of moderate size are located in the corners of the state, including Fayetteville and Fort Smith in the northwest, Jonesboro in the northeast, Hot Springs in the midwest, Texarkana in the southwest, El Dorado in the midsouth, and Pine Bluff in the Delta Region of the Mississippi River. These cities provide the population base for sizable medical communities and are the locations of Area Health Education Centers (AHECs) in most cases. Over the state as a whole, the number of physician practices is probably adequate to provide the necessary medical services, but in certain underserved areas, physician and other health provider shortages are common in the state. UAMS, based in Little Rock, provides a centralized point of referral for all medically complicated patients, and also provides medical and health education for the entire state. Except for the communities of West Memphis and perhaps Helena on the eastern border of the state who depend on the city of Memphis in Tennessee, all state communities relate to UAMS and Little Rock Hospitals as the major source of highly specialized medical care. The AHECs provide Family Medicine residency training in communities around the state, and have been of great assistance in improving the distribution of primary care physicians to the corners of the state. By far the most numerous specialty in Arkansas, Family Physicians provide most of the state's medical care. Specialists in obstetrics, pediatrics, internal medicine, surgery and others have practices in the more urban communities in the state. While Arkansas is geographically of modest size compared to some other states, the distances from cities such as Fayetteville and Texarkana from Little Rock require two and one-half to four hours to travel to UAMS and other central hospitals.

For families with little resources to travel, these distances represent significant barriers in access to highly specialized care.

2. The system of state agencies providing support to the health system for women and children

The Arkansas General Assembly in its 2005 session passed legislation formally merging the Department of Health and the Department of Human Services into a new Department of Health and Human Services. Tables of organization appear in Appendix I.

In its new organizational structure, the Division of Health will continue to prioritize health services according to policy set during the leadership of Dr. Fay Boozman, the former state health director. Health services are prioritized in three levels. Level I involves preventive health services that must be provided in Local Health Units in all counties. These include Immunization, Family Planning, WIC, STI clinic care, infectious disease outbreak management, Breast and Cervical Cancer Control, and environmental health. In the past, well child clinics fell in this category, but with Medicaid assignment of EPSDT children to primary care physicians in the private sector, these clinics are no longer provided by the Division of Health. Level II involves basic preventive services for which availability is necessary in all counties, but for which local health systems may have sufficient capacity. These include maternity care, and home health services. Level III are those preventive services that are optional for counties such as services for patients with diabetes and hypertension. Over the past several years, the former Department of Health has been developing request for proposal programs to fund competitive special projects in selected counties. Services provided through these resources include Abstinence Education, Unwed Birth Prevention, and Smoking Cessation.

The state of Arkansas managed the Title V program in the two different Departments. The Maternal and Child Health services were managed in the Arkansas Department of Health (ADH), and the Children with Special Health Care Needs services were managed within the Department of Human Services (DHS). That arrangement provided the administrative context for maternity and well child

services to be conducted in Local Health Unit clinics throughout the state, and for Children with Special Health Care Needs services to be managed in close relationship with the DHS Divisions of Developmental Disabilities and Children and Family Services, and with Medicaid. CSHCN services were and are closely associated with specialty services of the Department of Pediatrics at UAMS.

Many remarkable changes in these services have occurred in Arkansas, opening the way for major statewide reorganization. For example, the Medicaid Program reorganized the EPSDT Program to create the AR Kids First Program. Medicaid assigned all EPSDT enrolled children to primary care physicians (largely private doctors) and discontinued reimbursement to the ADH for EPSDT screening. At the same time, the new AR Kids First Program raised income eligibility for children of low-income families to 200% of poverty. (Federal State Child Health Insurance Program (SCHIP) funds enabled an increase in eligibility from 185% to 200% of poverty.) As a result the number of children in low-income families who were not covered declined. Without reimbursement, the ADH discontinued its well child clinics. ADH still provides services for children including immunization, injury prevention, newborn metabolic screening, newborn hearing screening and other prevention programs for children including SIDS. ADH uses the 30% of MCH Block Grant funds required to support health services for children to enhance immunization programs and maintain preventive and population-based services for children.

Another very significant change befell the ADH. In March 2005, Dr. Fay Boozman was killed in an accident on his farm. As State Health Director, he had been the major architect of a reorganization going on within the ADH for the last five years. To fulfill his term, Gov. Mike Huckabee named Dr. Paul Halverson of Little Rock as the interim director of the ADH.

Dr. Halverson, 46, joined the University of Arkansas for Medical Services (UAMS) College of Public Health in Little Rock in June 2004 as Professor and Chairman of the Department of Health Policy and Management. Prior to moving to Arkansas, he served for almost seven years as a member of the senior scientific staff at the federal Centers for Disease Control and Prevention (CDC) in Atlanta. At the CDC, Dr. Halverson was appointed to the Silvio Conte Senior Biomedical Research Service, a congressionally designated classification within the Department of Health and Human Services for the nation's top biomedical research scientists. He was the director of the Division of Public Health Systems Development and Research for the CDC. He had responsibility for strengthening the effectiveness of public health systems throughout the United States.

While in Atlanta, Dr. Halverson led the development and implementation of the National Public Health Performance Standards Program, the deployment of the National Health Alert Network and the advancement of the National Public Health Leadership Institute. He also helped develop a number of leadership and management education programs. He also served the World Health Organization as the director of the WHO Collaborating Center in Public Health Practice at the CDC. In that role, he provided support globally for the advancement of public health systems.

Prior to his appointment at the CDC, Halverson was a member of the faculty at the University of North Carolina School of Public Health, serving in the Department of Health Policy and Administration. Halverson was the associate director of the doctoral program in public health leadership and the senior health policy adviser to the North Carolina State health director. For 14 years prior to going to work at the University of North Carolina, Halverson was a hospital administrator. He worked in Arizona, Minnesota and Michigan.

Halverson received his doctorate in public health from the University of North Carolina at Chapel Hill and his master's degree in health services administration from Arizona State University. He has received numerous honors in the area of public health.

On June 9, 2005, Gov. Mike Huckabee named John Selig of Benton to head the largest agency in Arkansas government, the state Department of Human Services (DHS). Mr. Selig will replace Kurt Knickrehm, who is leaving state government to join the private sector, having headed the DHS since January 1999. Mr. Selig will begin his new duties July 1, 2005.

Mr. Selig, 44, is a De Queen native. He currently is the deputy director of DHS in charge of the divisions of Behavioral Health Services, Medical Services, Developmental Disabilities, County Operations and Aging and Adult Services. Mr. Selig received his bachelor's degree from Stanford University in 1982 and his master's degree in public administration from Princeton University in 1987. He served in the Peace Corps as a teacher in West Africa from 1982-84 and then was on the Little Rock staff of U.S. Sen. David Pryor in 1984-85. Mr. Selig began his service to the DHS in March of 1988, and has served there continuously since then except for a two-year interval when he served in the Department of Health administering the In Home Services Program. He was at the Health Department from 1994-96 before returning to DHS.

Mr. Selig has spent the last three years as the director of the Division of Mental Health Services at DHS. In that role, he focused on increasing consumer and advocate involvement in the state's public mental health system. He began a statewide mental health public awareness campaign that received a national award for excellence from the National Alliance for the Mentally Ill. Mr. Selig has served on numerous boards, including the state Minority Health Commission and the state Health Services Permit Commission.

During the 2005 session of the Arkansas General Assembly, the legislature enacted a reorganization of state agencies, combining the ADH and the DHS into the Department of Health and Human Services (DHHS). Mr. Selig will be the director of the new DHHS. That reorganization is under way, and will become official in mid-August, 2005. The ADH organizational units for financial management, personnel, and computer systems technology have already begun to integrate their efforts into the new Department. The remainder of the ADH will take its place as a Division along side those of Medical Services (Medicaid), Developmental Disabilities, Children and Family Services, Aging, and other units related to the health and welfare of Arkansas citizens. In addition, the General Assembly divided the position of the State Health Director into two positions, the Director of the Division of Health, Dr. Halverson, and the State Health Officer, Dr. Joseph Thompson. The State Health Officer role includes serving on the State Board of Health and as the chief spokesman for health in state government. Dr. Thompson is currently the Director of the Arkansas Center for Health Improvement in the College of Public Health. He is also a professor of pediatrics with the Department of Pediatrics, UAMS College of Medicine, and the Arkansas Children's Hospital.

The General Assembly also provided that the duties and responsibilities of the State Board of Health be brought into the new Department largely intact.

The new leadership structure of the Division of Health in DHHS will continue to relate to many organizations and leaders in state agencies and local communities. Links between health-related organizations in state government and the University of Arkansas for Medical Science have are remarkably stronger with the development of the College of Public Health. Links with the professional boards of Medicine, Nursing, and other disciplines remain strong. The new Division of Health will continue with its responsibilities to license hospitals in the state, and to relate closely with the Hospital Association. Other disciplines such as dentistry, pharmacy and chiropractic continue their representation on the Board of Health, along with medicine, nursing and hospitals.

Clinic services that are preventive in nature and represent "gap-filling" activities will continue in our 94 local health units in 75 counties. The top priority for these services is established in health agency policy. Level One services include environmental health, immunization, family planning, and WIC. These services are supported by a system of Franchise Agreements (FA). These agreements set out the requirements for service delivery conducted in communities as led by five Regional Teams. Level One services must be provided in all counties. Level two services are preventive and are carried out in counties with no alternative services for low-income families. Maternity services are included in Level Two. Some counties have local physicians and community health centers willing and able to provide prenatal care services for low-income women. In those counties local health units do not provide prenatal care. The provision of other more centralized services such as newborn hearing and metabolic screening, also Level One, are carried out not in the clinic context, but as a centralized

service depending on hospitals to obtain biological samples or hearing tests, and local health unit nurses to relate to families when abnormal findings must be communicated and arrangement made for follow-up. Level Three services are optional for counties. The State Laboratory continues to support local environmental and personal health services.

Arkansas's population stood at 2.7 million people as of 2004. Among states, Arkansas has high proportions of rural, low income and minority citizens. A very broad range of health measures in this state rank unfavorably compared to other states. These include many of the data trends captured in the MCH Block Grant performance measures. Arkansas' five health regions are diverse in geography and demography. The Central Region around Little Rock is relatively urban and well supplied with available health services for women and children. However, even in these counties low-income families experience barriers in access to care. All other regions are rural and poor and many are medically underserved as defined by HRSA programs. Counties along the eastern border of Arkansas, the Mississippi Delta are especially rural and poor and have high concentrations of minority populations, especially African American. Counties along the western border are mountainous and rural. They have fewer minorities, but are high impact for immigrant Hispanic families from Central and South America. A group of Marshallese families live in the far northwestern counties and experience outbreaks of several infectious diseases. Counties along the southern border of the state are also rural and poor, depending on farming and timber as their predominant source of income.

As the monumental task of merging the Department of Human Services (DHS) and the Department of Health (ADH) proceeds, it is unknown what the impact of that merger will mean to the Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) programs. The upcoming merger comes on the heels of the transfer of the Title V CSHCN program within DHS from the Division of Medical Services (DMS-the division that includes the state's Medicaid program) to the Division of Developmental Disabilities Services (DDS). In DDS, the Title V CSHCN program has found a similar family friendly "spirit".

As we look toward the year 2010, realizing that the merger of DHS and ADH will transpire within the next five years, it is very difficult to foresee how the Title V CSHCN program will look. The CSHCN staff will push to be involved to educate and inform as decisions are made about program and staff placement within the new organizational structure.

While reorganizing, the CSHCN program will need to be an articulate advocate for maintaining and even developing both reimbursement programs for special need children and important enabling services such as care coordination and transitional care.

B. AGENCY CAPACITY

With the support of thousands of dedicated colleagues and public and private partners, the new Division of Health will continue to address the health of women and children. August 13, 2005 is the official start date for the new Department of Health and Human Services. Agency capacity is described below by the maternal and child health subpopulations.

Arkansas has a variety of state statutes that guide the provision of services to mothers and children. There is no overall statutory authority for the MCH population, so existing statutes will be discussed within each of the subpopulations.

1. Preventive and Primary Services Infants and Pregnant Women

Maternity Medical Services works to ensure all pregnant women in Arkansas have access to early and continuous prenatal care, thereby reducing the number of preterm and low birth weight infants and lowering infant mortality and maternal morbidity and mortality.

Target Population

Pregnant women in Arkansas, specifically those with no other source of prenatal care. Currently 57 counties hold clinics in 64 sites.

Description of Services

Maternity clinics provide prenatal services, including risk assessments, laboratory, physical assessments, patient counseling, prenatal education classes, nutrition, social work counseling and referrals for high-risk care. Case management and follow-up ensures patients receive services needed. Medicaid eligibility is determined and, where possible, patients are referred to local physicians for continuance of care. Local Health Unit Prenatal clinics are located in 57 counties, with 64 sites. All local health units offer basic pregnancy assessment and counseling, with a referral method to local physicians. Working with the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS, ADH anticipates implementing new screening methods for smoking, depression, partner violence and substance abuse. State law requires that all pregnant women be tested for HIV, unless they have been counseled and have refused the test.

Licensed Lay Midwives promulgate regulations, monitor the practice of Midwives and their Apprentices, sponsor and staff the Midwife Advisory Board, pursues disciplinary action, and provide in-service. There are now 31 Licensed Lay Midwives and 9 Lay Midwife Apprentices. In 2004, 216 women began care with a lay midwife, with 157 of those women continuing in midwifery care through delivery. State law provides for the maintenance of a licensure program for midwives, and the Board of Health writes regulations in support of that statute.

Support for the Campaign for Healthier Babies, is both monetarily and in-kind. In-kind supports requests for coupon books and other information. Participates in planning the Campaign's activities and provider relations' activities.

In addition, the Department of Health managed the Home Health Program called In Home Services. Part of the care it provides is called the Maternal and Infant Program (MIP). MIP, if requested by a local health unit and as ordered by Dr. Nugent, will make home visits to pregnant women at risk. The risk can be simply that she is an adolescent who would benefit from a home assessment and further follow-up. In addition, MIP will visit pregnant women who have medical complications like pre-eclampsia requiring bedrest, diabetes requiring insulin therapy, infants requiring special monitors or IV therapy.

2. Primary and Preventive Services for Children

The purpose of the Child and Adolescent Health Program is to encourage community-driven public health by promoting safer and healthier communities through education, prevention, and intervention by ensuring that statistically driven initiatives are in place through integrated stewardship.

Target Population

Birth through adults for the State of Arkansas.

Description of Services

Child and Adolescent Health is comprised of different programs serving the needs of the communities in Arkansas such as Community Smoke Alarm Installation and Education Program, Fire & Fall Prevention of Adults, Core Injury, Violence Prevention/Intervention, Infant Hearing, and Childhood Injury Prevention.

Child and Adolescent Health provides the following services:

- Installation of smoke alarms in five hundred households per county;
- Training for senior citizens in fire and fall prevention;
- Establishment of coalitions and focus groups for core injury and violence prevention;
- Collaboration with Hometown Health Improvement Coordinators to identify areas that will benefit from the violence programs;

-Curriculum for various programs listed above.

Birthing hospitals report the initial hearing screen results of newborns to the Infant Hearing Program. A state statute establishes that all hospitals delivering over 50 babies a year will conduct physiologic hearing screening on newborns, and will report the results to the Department of Health. State statutes provide for the licensing and review of hospitals within the state, and regulations are promulgated by the Board of Health. The Board has established regulations regarding the provision of obstetrical and pediatric services. State laws also provide for the development of the newborn screening program for metabolic and other congenital illnesses. A recent change in this law established that the Department would conduct screening for PKU, Hypothyroid disease, Galactosemia and Sickle Cell disease, and other tests as provided for in regulation from the Board of Health.

Arkansas Safe Kids Coalition distributes free bicycle helmets to community groups, school groups, health fairs, and bicycle rodeos and provides preventive measures and education for children and caregivers on the importance of using seat belts.

The Abstinence Education Program awards subgrants to local communities to support abstinence education initiatives. This grant has a required match of three non-federal dollars for every four federal dollars awarded. Medicaid income from the Family Planning Program, combined with in-kind match from local communities meets this requirement. Each sub grantee is required to maintain records of clients served; develop a quarterly narrative progress report; and work with the state evaluator to determine the program effectiveness, assess student knowledge and behavior regarding sexual health values and practices. Technical assistance workshops provide knowledge and training of grant requirements to sub grantees. Site visits (monitoring) are performed to assure the quality of the data collected and to view abstinence interventions in the local communities.

Target Population

The Abstinence Education Program supports abstinence education for youth and young adults up to age 24.

Grants foster abstinence education (educational or motivational) programs that (1) have as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity; (2) teach abstinence from sexual activity outside marriage as the expected standard for all school-age children; (3) teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems; (4) teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity; (5) teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects; (6) teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; (7) teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and (8) teach the importance of attaining self-sufficiency before engaging in sexual activity.

The Office of Oral Health (OOH) envisions Arkansas as a state where everyone enjoys optimum oral health through primary prevention at the community, healthcare professional and family levels. This can be accomplished through: accessible, comprehensive and culturally-competent community-based oral health care provided through a variety of financing mechanisms; educational opportunities throughout life that will allow individuals to make better decisions for their health; and informed and compassionate policy decisions at all levels of government.

Target Population

Infants, children, adolescents, adults, and the elderly in the State of Arkansas.

Description of Services

OOH colleagues provide education and awareness on a variety of oral health issues including fluorides and fluoridation, dental sealants, infection control, oral cancer, access to care, tobacco

cessation and prevention, and family violence prevention.

OOH assists communities with water fluoridation through community presentations and providing funding through the Preventive Health and Health Services Block Grant.

- Working with the Division of Engineering, OOH provides water plant operator trainings throughout the state.

- Working through the Arkansas Oral Health Coalition, OOH provides dental sealants to at-risk children.

- OOH colleagues conduct a wide variety of assessment activities throughout the state on children, adolescents and the elderly. Reports on the various assessment activities are available and are combined into an oral health burden document.

State legislative activity requiring fluoridation of public water supplies has occurred in each of the past two sessions.

3. Services for Children with Special Health Care Needs

Registered Nurses housed in 4 of the 26 community-based offices provide CSHCN care coordination and payment for services for individuals who qualify medically and financially for Title V CSHCN services and do not have Medicaid coverage. Approximately 500 children and youth are served each year using Title V funding alone or in cooperation with private insurance to pay for medical care for eligible conditions. Approximately 26% of the current active cases are undocumented Hispanic children and youth that do not qualify for Medicaid because of their citizenship status. Many of these individuals have devastating health conditions that would qualify for SSI coverage if their citizenship status were different. However, since they are not eligible for SSI, the cost of their health care is born by the Title V CSHCN program. Another group of children and youth receive limited services from Title V CSHCN. Approximately 40% of the applications received for children and youth are approved for payment of a diagnostic evaluation prior to any eligibility determination being made. Many of these individuals are subsequently found to be ineligible for ongoing coverage due to being financially ineligible or diagnostically ineligible. By helping pay for the diagnostic services, the Title V CSHCN program is able to alleviate some of the financial burden felt by families who are new to the Special Needs arena. During the time the application is pending, the nurses are able to make referrals for services the family may subsequently need and be quite unaware that the services are available or even that they will be needed. As funding permits, Title V CSHCN works with families of eligible children and youth covered by Medicaid to fund purchases of equipment that is not covered in the Medicaid state plan. Some of these items include IPV machines, van lifts and wheelchair ramps. Another service provided as funding allows is payment for children and youth with special needs to attend various Med-Camps during the summer. Attendance at these camps allows time for peer interaction and socialization while teaching diagnosis-specific self-care in a fun camp environment.

Title V staff provide Medicaid-reimbursed care coordination assistance to approximately 3,200 children and youth with special needs and their families. The Medicaid recipient must be medically eligible for the Title V CSHCN program unless the individual is under age 16 and receives SSI or TEFRA benefits. Those recipients may request and receive Title V CSHCN care coordination assistance regardless of whether the diagnosis qualifies them medically for the program. The Title V CSHCN program cannot bill for care coordination assistance if any other program or provider is working with the family and billing Medicaid for care coordination. Staff in the community-based offices consist of either a Service Specialist, Social Worker or Registered Nurse trained as a Title V CSHCN care coordinator and a medically trained Secretary who has received training and experience in care coordination. A broad-based knowledge of programs and providers of services in the state and local community allows Title V CSHCN staff to make appropriate referrals in a timely manner. Some of these referrals are for Special Needs Funds and Integrated Supports, DDS programs that provide timely relief to families with emergency needs. Title V CSHCN staff also make referrals and assist

with applications for the ACS Home and Community Based Waiver.

The Part C Early Intervention is managed by Title V CSHCN and oversees provision and coordination of services to over 3,000 infants and toddlers with a developmental disability or a developmental delay and to their families annually. Service coordinators assist families in accessing local services and in funding services that are not otherwise available. Regular contact is made with medical providers in local communities to assure that referrals are made as needed. This contact also assures that Title V CSHCN services are presented to the medical providers. Eligible infants and toddler's ages birth to 36 months and their families may access an array of sixteen services. Services are provided as a result of a multi-disciplinary team decision and service plan. Title V CSHCN staff serve as Service coordinators for Part C Early Intervention services with an average caseload of 148. This far exceeds the national recommendations.

A Unit composed of Title V CSHCN staff also serves as Waiver Specialists for the Alternative Community Services Home and Community-Based Waiver through DDS Children's Services. A staff of 9 serves approximately 1,000 waiver recipients less than 22 years of age who have not completed their education. Title V Regional Managers and the Program Administrator provide assistance. The Waiver Specialist is responsible for assuring that the individual's special needs are met through the plan developed by the child/youth, their family, the provider and other interested parties. The Title V CSHCN staffs' knowledge of medical conditions, educational services and the Medicaid program has been very helpful in this process.

Title V CSHCN staff coordinate the Children's Services Respite Waivers for the Mentally Retarded/Developmentally Delayed and the Physically Disabled. Central office staff manages these waivers after receiving input from staff that work with the children/youth locally. An invitation to apply for the Respite Waivers is mailed to parents/guardians of all children and youth covered by SSI or TEFRA. New referrals for the Respite Waivers come from within DHS and the Title V CSHCN program. Title V CSHCN staff work closely with Partners for Inclusive Communities, a subcontractor for a Respite for Children Grant, to determine how the current Respite Waivers can be revised to provide easier access.

Title V staff have provided services through the Medical Home Grant. The grant ended March 31, 2005; however, a no added cost extension has been granted. The extension will provide for the continuation of Project DOCC (Delivery of Chronic Care). This project has been coordinated by Rodney Farley of Title V CSHCN and has trained families that serve on the Title V CSHCN Parent Advisory Council to give an overview of the daily tasks that are involved in the lives of CSHCN. They invite Resident Physicians from the University of Arkansas Medical Sciences into their home for a glimpse into their lives and the changes that occurred with the CSHCN. The purpose of Project DOCC is to give physicians a better understanding of what CSHCN and their families go through on a daily basis and how their needs impact the entire family.

Through Title V CSHCN contact with families, a database of over 16,000 children and youth is maintained with whom we provide information via an annual newsletter. The newsletter is sent on a quarterly basis to families who have requested Title V CSHCN care management assistance, those who receive services paid for by Title V CSHCN funding and those whose ACS Home and Community Based Waiver case is coordinated by Title V CSHCN staff.

The Child and Adolescent Service System Program (CASSP) was established by the Arkansas legislature in 1991 because the children and youth of the state were not adequately served by the mental health system. A statewide council made up of legislatively appointed membership from Human Services, Health and Education oversees CASSP. Membership also includes consumers, family members, mental health providers and advocacy groups. Fifteen Regional CASSP teams serve the children and youth around the state. Title V CSHCN staff are members of the regional teams and work as part of the team to assure that appropriate services are received.

DHS is the lead agency for an innovative program called Together We Can (TWC). DDS is the

division responsible for the coordination of TWC. Title V CSHCN staff are vital members of the local team. TWC is a multi-agency, multi-departmental program that is available in 26 counties. It provides services to children who have multiple needs but have been unsuccessful in services provided in the past. TWC services address intense emotional, interpersonal, or behavioral challenges, a lack of success in traditional services, the need for services from multiple agencies, and the desire to remain in the community.

Title V CSHCN staff provide leadership of Local Interagency Collaboration Councils (ICC). These teams are regional support for the State ICC that is the state's group monitoring the Early Intervention program. Membership in the local and state team includes DDS staff, Department of Education Early Childhood staff, providers and consumers.

Title V CSHCN staff are members of Hometown Health Initiative (HHI) teams around Arkansas. The CSHCN staff is responsible for assuring that the needs of CSHCN are brought before the local teams. Child Case Review Committee (CCRC) is an interagency team within DHS that brings staff from the Division of Children and Family Services (AR Foster Care Agency), the Division of Youth Services, the Division of Developmental Disabilities Services, the Division of Behavioral Health Services, the Division of Medical Services (Medicaid) and the DHS Director's Office to discuss problematic cases that cross divisional lines. The Title V CSHCN Assistant Director is a member of this committee.

Arkansas State Hospital (ASH is Arkansas' state-owned inpatient mental health facility) Adolescent Utilization Review Committee is made up of Psychiatrists, Psychologists, nurses, counselors, and administrators from the facility and the Program Administrator from the Title V CSHCN program. The committee meets twice monthly to discuss treatment and post-discharge plans for dually diagnosed (Mentally Ill and Developmentally Delayed) children and youth who receive treatment at their facility.

The Title V CSHCN Program Administrator is a member of the Department of Health Oral Health Advisory Committee and Genetics Services Advisory Committee and these are explained in greater detail elsewhere in this application. The needs of CSHCN and their families are brought to the attention of these groups. Other committee members have given expert advice and referrals when problematic issues have arisen involving CSHCN.

The Title V CSHCN Unit Manager serves on the Medical Home committee for the Arkansas Early Childhood Comprehensive Systems (AECCS) grant with DHS Division of Child Care and Early Childhood Education.

By agreement with Arkansas Social Security Disabilities Determination Services office, information is forwarded to the Title V CSHCN program when they receive an application for SSI on any child or youth less than 16 years of age. Upon receipt, CSHCN staff review each referral to determine if the individual is already receiving Title V CSHCN services. If not, further referrals are made for other services/programs for which the individual may also be eligible, such as Part C Early Intervention, DDS, Title V CSHCN and Mental Health services. Approximately 2,000 such referrals were made during FFY 04.

4. The WIC population

The mission of the Women, Infant and Children program (WIC) is to improve the health of infants, children and childbearing women by directly supplementing their diets with foods rich in nutrients they need, providing nutrition education and counseling and referrals to other services.

The mission of WIC Farmers' Market Nutrition Program is to encourage the consumption of fresh fruits and vegetables by WIC participants and encourage the development of farmers' markets.

Target Population

WIC: Pregnant, breastfeeding and postpartum women, infants and children under age five are eligible if they live in Arkansas, are income eligible and have a condition or living situation which places them

nutritionally at risk. Income eligibility is based on 185% of the federal poverty guidelines.

FMNP: Women and children who are WIC participants in the counties with authorized farmers' markets are eligible.

Description of Services

Risk Assessment: A screening to determine nutritional status is performed on each applicant by a nurse, nutritionist, home economist, or physician.

Food: WIC participants receive nutritious, prescribed foods and purchase these foods as listed on WIC checks (bank drafts) at local grocery stores. FMNP participants receive coupons, not to exceed \$20, to purchase locally grown fruits and vegetables at farmers' markets.

Nutrition Education:

- Nutrition Counseling - Participants with potentially serious nutrition-related health problems are scheduled for individual counseling by nutritionists.

- Nutrition Education -- All participants or parents of participants are offered nutrition education including the selection and use of fresh fruits and vegetables in counties where FMNP is available.

- Breastfeeding Promotion and Support - All pregnant women are informed of the benefits of breastfeeding their infants. Breastfeeding women receive support services from trained health providers and may receive breast pumps.

Referrals to Other Services: WIC participants are referred to other services as needed by local clinic staff. Strong emphasis is given to childhood immunizations and prenatal care.

5. Women and men of reproductive ages (Family Planning)

The purpose of the Reproductive Health Program is to provide reproductive health services to women and men, enabling them to choose the number and spacing of children and prevent unplanned pregnancies. Reproductive Health services include health history assessment, laboratory tests, physical assessment, contraceptive methods, health education, treatment and referral.

Target Population

Men and women of childbearing age in the State of Arkansas, primarily the low-income clients who are uninsured and under insured.

Description of Services

The Reproductive Health Program provides, through ADH and delegate agencies, clinic based family planning services to women in need of publicly supported services. Eighty percent of these women will be at or below 200% of poverty according to declared income and family size. In addition, the program provides outreach and education to hard to reach populations regarding family planning. This includes education on abstinence and male responsibility. The program also detects precancerous and cancerous changes of the uterine cervix through Cervical Cytology Screening.

The objective of unwed birth prevention efforts is to prevent pregnancies to unmarried teens throughout Arkansas. A variety of methods are utilized to include health education, outreach, and increased access to family planning services. During 2004 nine (9) County Coalitions targeted eleven (11) counties and reached eight thousand one hundred ninety-six (8,196) youth through facilitation of "Programs That Work" curricula. An additional eight hundred twenty-seven (827) youth received family planning services while two hundred thirty-seven (237) participated in Teen Outreach Programs, fifty-nine (59) participated in male responsibility programs, and five hundred seventy-two (572) utilized Baby Think It Over simulators.

In March 2004 a request for proposal (RFP) for State Fiscal Year 2005 was disseminated targeting

twelve (12) counties. Eleven County Coalitions responded and were awarded grants, including three (3) Hispanic Heritage (HH) applicants. Also funded to address unwed birth issues, HH grantees focus on the Latino population and are located in the Northwest, Southwest, and Central Public Health Regions of the State. Program requirements are the same as for the other County Coalitions.

C. ORGANIZATIONAL STRUCTURE

A. Introduction

The Governor of Arkansas Chairs a Cabinet that included Both the former Department of Health and the Department of Human Services. As of August 13, 2005, that arrangement will formally change. The Department of Health (ADH) will be merged with the Department of Human Services (DHS) to form a new Department of Health and Human Services in which the health agency will take its place as the Division of Health (DOH) beside related Divisions such as Developmental Disabilities (where the CSHCN program is now placed), The Division of Children's Services, the Division of Medical Services (Medicaid) and others.

The two departments have already co-located several administrative "like" functions with the intention of making them more efficient, and also strengthening them. Those functions include:

Legal Services - June 16

HIPAA Office - June 16

Payroll/Benefits (part of Financial Management) - June 21

Human Resources- June 21

EEO Office - July 1 (with a satellite office maintained at ADH)

Financial Management- July 5

The Board of Health remains intact in its membership and regulatory responsibilities in the new Department of Health and Human Services.

B. Organizational structure by the MCH subpopulations

1. Pregnant women and infants organizational structure

The Perinatal Program is still housed in the Women's Health Work Unit of the Department of Health, now called the Division of Health in the new Department of Health and Human Services. The Women's Health Work Unit is located in the Family Health Services Unit of the Statewide Services Business Unit. A board certified obstetrician gynecologist and a public health nurse with long experience in local health unit maternity services are located in Women's Health. A physician who is board certified in Preventive Medicine and residency-trained in Obstetrics and Gynecology, who provides leadership to the Family Health Services Unit, also provides guidance and clinic services to the clinic services managed in the Women's Health Work Unit.

2. Organizational structure for children

The Child and Adolescent Health (CAH) Programs, still located in a Work Unit by that name, remain in the Family Health Services Unit of Statewide Services in the new Division of Health. Until recently, the

CAH work unit was guided by a physician who is board certified in Preventive Medicine and clinically trained in pediatrics. That physician resigned to begin a residency in Family Practice. The Division of Health plans to replace that position, and recruiting efforts will soon begin. Two other positions are open in CAH, a Work Unit Leader and the manager for the Injury Prevention Program. With the physician, these two positions will provide critical new leadership in programs for children. The Family Health Services Unit leaders intend for CAH to bring new emphasis to developing interagency collaboration and broad partnerships in improving services for children. Heavy use of the Block Grant dollars to sustain the immunization program is planned, but a new emphasis is to be brought to community coordination, outreach and case management. These emphases should all benefit from the merger of the two former departments.

3. Organizational structure for Children with Special Health Care Needs

Historically, in Arkansas the Title V CSHCN program has been housed in DHS. The transfer of the Title V CSHCN program (formerly known as Children's Medical Service or CMS) from the Division of Medical Services (Arkansas' Medicaid entity) to the Division of Developmental Disabilities Services led to reorganization within DDS to structure the agency into Children's Services and Adult Services with other sections providing fiscal management and quality assurance resources. Prior to the intradepartmental move, the Title V CSHCN program and DDS served many mutual consumers. DDS had and still has a scope of eligibility that includes Cerebral Palsy, Seizures, Autism, Mental Retardation and any "other condition" that causes an individual to function as though they are Mentally Retarded. The Title V CSHCN program covered Cerebral Palsy, Seizures and some of the "other conditions", but did not cover Autism and Mental Retardation. Title V CSHCN, following national definitions, covered and still covers a wide range of medical conditions such as Cancer, type I Diabetes, severe Asthma, Spina Bifida, orthopedic anomalies, injuries and many, many other conditions. These conditions are outside the range of typical DDS consumers so that the DDS scope of service is somewhat narrower than CSHCN. As the Title V CSHCN staff transitioned into DDS they have been assigned duties and caseloads for other DDS programs. These programs provide services to CSHCN and are an additional resource for families.

Although there are more employees, the combined caseloads remain too large for staff to effectively manage. This has led to concerns among veteran Title V CSHCN staff, the Parent Advisory Council and others that traditional Title V CSHCN consumers are being neglected. Using the long-held definition of CSHCN, all of the individuals served through the DDS programs are children with special needs and are deserving of Title V CSHCN staff efforts to assist in meeting their needs and personal goals. The over-riding issue is whether it is realistic to believe that a relatively small staff can adequately handle the caseloads that result from these various programs.

In the Arkansas Department of Health and Human Services the Division of Health (DOH) will retain, at least for now, its existing regional configuration of counties. Divisions in the former DHS also had separate regional configurations. Each DOH region has a Regional Leadership Team headed by a Regional Director. These teams and directors provide supervision and guidance to District Managers within the Regions, who in turn manage the Local Health Unit administrators (Hometown Health Leaders).

4. Organizational structure for WIC services

The WIC Program, along side the Women's Health and Child and Adolescent Health Work Units, is housed in the WIC Work Unit of the Family Health Services Unit. WIC clinic services are provided in all 94 local health unit sites, as are food instrument services. Farmers' markets are developed in selected sites in the state. The WIC Work Unit is supported by the Regional Leadership Teams who assure management through the District Managers and Administrative Leaders of Local Health Units.

5. Other structural aspects of the new Division of Health

The Hometown Health Improvement initiative of the former Department will also be carried forward to

the new Division's efforts. Local Health Unit Administrators, also called Hometown Health Leaders in each county, are responsible to oversee and carry out the processes of organizing community leaders to identify and address health problems of concern to the community. In addition, they provide or obtain technical assistance in grant writing and other administrative support for active community leadership groups.

Located for the moment in the Offices of the Director, the leaders of the Healthy Arkansas Initiative provide leadership and administrative support for the effort to improve nutrition and physical activity in schools, workplaces, and living situations for the elderly. Especially important, the Child Nutrition Advisory Committee, created by Act 1220 of the General Assembly, provides policy guidance to schools and community health agencies. While this Committee is administratively supported by the Department of Education, DOH senior staff provide strong leadership in its deliberations.

The organizational format of the Division of Health is only now being discussed. Dr. Halverson is part way through a program-by-program briefing, and developing a new table of organization will probably await the completion of that process. So, to some degree, the organizational arrangements described above may change, come the fall or the next calendar year.

As the organizational structure of the new Department, and the Division of Health develop, they will be posted on the Health Division's web page. Interested parties can access that page at www.healthyarkansas.com.

D. OTHER MCH CAPACITY

1. Introduction

Other capacities include the central and regional staff that work on MCH programs. The Statewide Services Business Unit is headed by Mr. Donnie Smith, a professional health educator who has had long experience with management of many health programs in the Division and former Department. In the past, Mr. Smith served as the Administrative Director of the MCH Section when that existed as an organizational unit. Mr. Smith is assisted by Ms. Renee Patrick, a public health nurse with previous administrative experience managing chronic disease programs for the former Department who now serves as the Deputy Director. Mr. Ron Stark serves as the Administrator for Statewide Services. He has long experience with management of MCH programs in the Department, and also with management of Medicaid programs in DHS that relate to women and children. Ms. Carladder Parham serves as the Director of the Family Services Unit of Statewide Services. Ms. Parham has served in many roles in the Department including, Director of Division of Health Records Management, Colleague Development Leader, and Grants Administration Supervisor. Medical Leadership is provided by Richard Nugent, MD, MPH, a board certified specialist in Preventive Medicine with residency training in Obstetrics and Gynecology and a masters in public health with an MCH concentration. He has devoted his career to perinatal and other MCH programs since 1974. Ms. Li Zheng assists Ms. Parham and Dr. Nugent as the MCH Epidemiologist, maintaining data files, helping with data analysis, responding to queries about MCH data, and helping to write the MCH Block Grant.

2. Other MCH capacities can also be described by the MCH subpopulation group.

a. Infants and Pregnant Women

The OBGYN and Pediatric Departments of UAMS provide medical leadership for infants and pregnant women that extends to all parts of the state. The Maternal and Fetal Medicine (MFM) faculty, and the Neonatology faculty, provide medical training for obstetricians and pediatricians who graduate from residency training to practice in larger communities. The two subspecialty faculties also conduct an annual Perinatal Conference in Little Rock, attended by obstetricians, pediatricians, and family physicians, as well as hospital and office nurses in relevant practices. With contractual support from the Division of Health, the MFM Division provides outpatient clinic services for pregnant adolescents, and a special clinic for pregnant women with gestational diabetes. These clinic services and the

prenatal clinics in local health units throughout the state are served by a coordinated system for consultation and referral operated by the high risk maternity services of UAMS. The Directors of the Maternal Fetal Medicine and Neonatology Divisions, with financial support from the Medicaid Program, have begun an effort called Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS). ANGELS has many purposes and activities. Among them is a statewide telemedicine network for obstetricians and neonatologist. This network holds conference every Thursday morning at 7:00 AM to present cases, discuss new evidence-based guidelines for obstetrical and newborn care, and to include community physicians in the process of writing the ANGELS guidelines. They are published both on the UAMS web page and by distribution of written copies to physicians in appropriate specialties. MCH staff from the DOH actively participate in these efforts.

The Community Health Centers Program of the Division, aided by the Primary Care Association of Arkansas, develops and maintains the network of 51 Community Health Centers throughout the state. Many of these Centers provide obstetrical care, and are located in medically underserved counties. The Area Health Education Centers train family physicians and also provide training in obstetrics, including the ability to perform cesarean sections for those physicians interested in this practice. While the AHEC's primary objective is training, a significant capacity to provide prenatal care exists in the AHECS in certain communities. The Primary Health Care Association supports the Statewide Health Access and Resources Program (SHARP), a collaborative planning and policy development group intended to bring together HRSA funded programs in the state. MCH staff participate actively in these efforts.

b. Children's Services

The Department of Health contracts with the Department of Pediatrics at UAMS for certain services to children. Primarily this contract is intended to provide coordination of hospital discharge plans for newborns leaving neonatal intensive care. The Pediatric Department's Neonatology services work very closely with the maternal fetal medicine services to coordinate perinatal services at UAMS. The two services together mount an annual perinatal conference training over 300 health professionals, mostly doctors and nurses, regarding new developments in perinatal medicine, and in the development of programs for infants and pregnant women.

The ADH and DHS in their former arrangements have had an ongoing liaison committee that met on an approximately monthly basis. In the new Department this function will happen more routinely during regular meetings of the Division Directors.

The Arkansas Children's Hospital (ACH) is among the top children's hospitals in the country. It provides subspecialty care, conducts research, and assists with public awareness and promotional aspects of developing services for children. ACH has developed outreach clinics for many pediatric specialties in more rural areas of the state. In addition to the Pediatric Department of UAMS, it is the main institutional provider of highly specialized pediatric services in the state. It operates a helicopter transport system for emergency evacuation of sick newborns.

c. Services for Children with Special Health Care Needs

The Director of the Division of Developmental Disabilities Services in DHS is James C. Green, PhD. His background is in Special Education. Current program leadership includes Regina Davenport, Assistant Director for DDS Children's Services. Ms. Davenport has a B.S. in Psychology from Arkansas State University with post-graduate work in counseling and Special Education. Her professional background is in developmental disabilities. Nancy Holder, RN, Program Administrator has an Associates Degree in Nursing from Memphis State University. Her professional background is in CSHCN, typically the medically involved child and youth. Eldon Schulz, M.D. with the University of Arkansas Medical Sciences Department of Pediatrics is currently serving under contract as Medical Director for the Title V CSHCN program. His professional background is in Developmental Pediatrics.

Since the transfer of the Title V CSHCN program from DMS to DDS, the make-up of the casework staff has expanded. A statewide Regional Management team of six includes four Registered Nurses, one Social Worker and one Service Specialist. Each of these Regional Managers supervises employees that include Registered Nurses, Social Workers and Service Specialists. Title V CSHCN staff are housed in 26 of the 75 counties in the state in DHS-operated offices. The RNs on staff have a minimum of two years experience when hired, with the current average years of experience with CSHCN being 19 years. The Social Workers on staff are licensed Social Workers or are individuals that have education and experience with CSHCN and are in positions which allow them to function in a Social Work capacity. The Service Specialists must have either a BS or BA degree with 2 years experience working with the developmentally disabled. The Title V CSHCN program currently has on staff: 22 Clerical Staff; 15 Registered Nurses, 7 Social Workers, 9 Service Specialists and 1 Psychological Examiner in community-based offices. There are 8 Management staff with 4 housed in community-based offices and 4 in central office. There are 23 Central Office support staff (administrative and clerical). Of the 85 total employees, 8 have children with special health needs. One is the Parent Consultant, 3 are Registered Nurses, 2 are Social Workers and 2 are Service Specialists.

Rodney Farley serves as Parent Consultant for the Title V CSHCN program. In this position he serves on a number of committees as a parent of a child with special needs and as an advocate. The committees he serves on include Partners for Inclusive Communities (Arkansas' University Affiliated Program) Consumer Committee; Arkansas Parent Information Exchange; Parent Training Information Governing Board; Advocates Needed Today (ANTS); Can-Do Committee; Parent Educator Advisory Committee; Arkansas Children's Hospital Rehab Advisory Committee and he serves as Family Voices Region VI Coordinator. Rodney works with the Title V CSHCN Parent Advisory Committee. As the parent of a young adult with special health care needs, he is able to give advice and assistance to parents with children of all ages.

The Parent Advisory Committee (PAC) for the Title V CSHCN program was formed 15 years ago and involves volunteers from around the state that are parents of CSHCN. The PAC meets quarterly to discuss issues and concerns related to the Title V CSHCN program. The PAC members are responsible for setting up local meetings to take information to more parents and work to set up support groups around the state.

The State Center for Health Statistics (SCHS) manages many data bases that are of critical importance to MCH, especially birth and death certificate, hospital discharge, PRAMS, BRFSS data bases. SCHS also manages professional registries for licensed health professionals, and many other data bases. The Center maintains a staff of highly skilled statisticians who are trained in SAS software use. They assist epidemiologists and program directors with data needs for agency performance, strategic planning, and program registries such as cancer and immunization. The SCHS manages the State Systems Development Grant (SSDI) which supports a rich network of data linkages being developed by the Health Department. For example, with SSDI and other resources have enabled SCHS to link birth certificates to infant death certificates, hospital discharge data, PRAMS survey data, Medicaid enrollment and billing information, and a variety of other data sets. The SSDI grant, along with other resources provides as much state data capacity as programs can use. This year's block grant application, requiring the 5 year needs assessment, called for a number of new measures. The SCHS was able to respond to these requests in a very timely manner with up-to-date information.

E. STATE AGENCY COORDINATION

E. State Agency Coordination

Introduction

State agency coordination exists on many levels including state government human service agencies, state-level commissions and partnerships (both existing and developmental), state-local health agency relationships, and local human-services agency interactions.

State government and human services agencies

Subsequent to July 15, 2005, the new relationships being developed in the new Department of Health and Human Services have clarified. A state agency organizational chart is attached as Appendix I. The Director of the Department of Human Services sits on the Governor's Cabinet. An office of Chief Council and an Office of Communications respond directly to the Department Director, as do the Chief Health Officer, Dr. Joseph Thompson, (a new position), and two Deputy Directors. The Deputy Director for Health, Mr. Ray Scott who has played many strong leadership roles in both health and human services in the past, supervises six Divisions including Health, Developmental Disabilities (Children's Medical Services and disability determination activities are here), Behavioral Health, Aging and Adult Services, Medicaid, and County Operations. The second Deputy Director, Ms. Janie Huddleston who is also very experienced in human services programs, supervises the Divisions of Children and Family Services (caseworkers), Youth Services, and Child Care and Early Childhood Education (day care settings), among others. Vocational Rehabilitation exists in a separate department. The new Department of Health and Human Services is now initiating intradepartmental coordinating and planning groups, and Division of Health leaders at the level of its four Center Directors are participating on these committees.

State-level commissions, partnerships and advocacy groups

Among the many such groups, a few stand out as being particularly important. Longstanding commissions include the Commission on Rape, Child Abuse and Domestic Violence and the Child and Adolescent Service System Program (CASSP). They bring policy and public prominence to these issues. The Arkansas Advocates for Children and Families has played a major role over the years in public policy for the needs of children in general. The Interagency Coordinating Committee was established for IDEA and continues to help state agencies collaborate around the educational and health needs of at-risk children.

Several developmental state partnerships and institutions are making great strides in collaborative efforts for children. Among them the most prominent as a new effort is the Child Health Advisory Committee (CHAC). ACT 1220 of 2003 created this group to address childhood obesity and develop statewide nutrition and physical activity standards. The Committee meets monthly and makes policy recommendations to the State Board of Education and the State Board of Health. Major tasks mandated by the Act include: 1) Removing elementary school student in-school access to vending machines offering food and beverages; 2) Developing recommendations to ensure that nutrition and physical activity standards are implemented to provide students with the skills, opportunities and encouragement to adopt healthy lifestyles; 3) Requiring schools to include as part of the annual report to parents and the community the amounts and sources of funds received from competitive food and beverage contracts; 4) Requiring schools to include as part of each student's health report to parents an annual body mass index (BMI) percentile; and 5) Requiring schools to annually provide parents an explanation of the possible health effects of body mass index, nutrition and physical activity. Organizational memberships in the CHAC include: Division of Health, Dietetic Association, Academy of Pediatrics, Academy of Family Practice, Association for Health, Physical Education and Dance, Heart, Cancer and Lung Associations, College of Public Health, the Arkansas Center for Health Improvement, Arkansas Advocates for Children and Families, U of A Cooperative Extension Service, Department of Education, School Food Services Association, School Nurses Association, the Association of Education Administrators, and the Parents and Teachers Association. The CHAC made strong recommendations to the Department of Education, and the Department Adopted regulatory requirements with direct impact on the nutritional environment in schools.

In 2002 the University of Arkansas for Medical Sciences (UAMS) announced the opening of the College of Public Health (COPH), in partnership with the Arkansas Department of Health. This summer (2005) the COPH will be dedicated and named in honor of the late Fay Boozman. The COPH includes the shared missions of 1) meeting the public health workforce needs for the future and 2) demonstrating how public health approaches can address the health needs of Arkansans via model

community programs. Pilot sites for teaching and learning also serve as innovative laboratories for new and creative approaches to old problems. Students learn, with the expert aid of local citizens, schools, hospitals, and faith groups about community-based health improvement. The CPH statewide approach to education includes partnerships with other universities and institutes of learning. For example, students may choose from approved courses at any of several state universities, or via the Internet from an even broader range of course options. During the 2003-2004 academic year, the CPH offered a Post-Baccalaureate Certificate, Master of Public Health (MPH), and DrPH in Public Health Leadership degree programs.

As with other UAMS colleges, the standards of teaching and learning are high and the resources for academic and social life are excellent. The mission of the College of Public Health at UAMS is to improve health and promote well-being of individuals, families, and communities in Arkansas through education, research, and service. The College of Public Health has elected to address its mandate to improve the health of Arkansas by adopting a community-based health education model. Our long-term vision is of "optimal health for all Arkansans." By joining forces with pilot communities, the College establishes a model process for statewide health improvement. CPH students, faculty and staff participate in close partnership with local organizations, citizens and public officials. In-service teaching and learning opportunities for CPH students will be concentrated in these pilot communities to the benefit of all involved.

State/Local coordination in health

Within the Division of Health, new organizational relationships are becoming clearer. A table of organization appears in Appendix J. Four new centers are now being formed. Each Center will have a Director, an Associate for Management and Operations, and an Associate for Science. The MCH Block-related programs are located mainly in the Center for Health Advancement, (Sections on Child and Adolescent Health, Women's Health, and "Connect Care" and the MCH Block Grant Managers are located here) and also in the Center for Health Protection (Sections on Immunization/Communicable Disease and Injury Prevention for adults and children). Both of these Centers will relate closely to the Center for Local Public Health which administers the regional and local offices of the Division. The Executive Committee, composed of those in the Director's office and the Directors of the four Centers assures coordination of these units, and directs the common use of agency funds at the state and local levels. The Center for Local Public Health administers the five Regional Directors and their leadership teams, which in turn, administer Local Public Health Units. At the local level, each county has a Hometown Health Improvement Leader (this name may change) who carries the responsibility to develop and maintain a group of community leaders or an actual Hometown Health Coalition to coordinate broad health initiatives at that level. Hometown Health Initiatives (HHI) throughout Arkansas offer a variety of publications and other resources to local communities that want to take ownership of health problems and work to identify and implement solutions that improve the health of the citizens. Given the state's emphasis in recent years on Tobacco, obesity, and physical activity it is not surprising that prominent among the materials being used are brochure such as 5-A-Day and Farmer's Market, guidelines for Healthy Vending, recommendations for making physical activity a part of your life, and facts and services about amoking and spit tobacco, second hand smoke, and smoking cessation.

Somewhat along these lines, state and local coordination efforts have been dramatically impacted by hurricanes Katrina and Rita, in that Arkansas experienced the influx of an estimated 70,000 evacuees. Three emergency operating centers were set up to coordinate this response, one in the Governor's Office called Operation KARE, one in the Arkansas Department of Emergency Management, and one in the Division of Health. While maintaining clear communication among these three operating centers was at times difficult, the state's response to evacuees was timely, coordinated, and more than adequate in terms of making hotels and motels, shelters, churches, and even private homes available to people from Louisiana, Mississippi and Texas. At least in part due to the new Department of Health and Human Services, local coordination of health units and county human services operations occurred. At the height of the influx of evacuees Arkansas had opened many more shelters with much larger capacity than turned out to be necessary. Church camps played a prominent role in this effort, a true public-private collaboration. Because HRSA's review process

subsequent to the July 16th application deadline offered states an opportunity to respond to the reviewers' input, we were able to include this additional information.

CSHCN STATE AGENCY COORDINATION

In its relatively new location in the Division of Developmental Disabilities in DHHS, the Children's Medical Services (CSHCN) Program is working more closely with other programs for developmentally disabled children, and with Medicaid. Arkansas Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is currently undergoing a revitalizing effort to increase screens through increased information sent to families and providers in mailings from the Medicaid contractor. These efforts should help increase EPSDT screenings. The Title V CSHCN staff routinely monitor the screens for the children and youth for which we are responsible for case management. When the EPSDT screening responsibilities were given solely to the Medicaid recipient's primary care physician, the DOH ceased providing the EPSDT services in areas of the state that were not medically underserved. This has led to difficulty in getting timely screenings done due to heavy physician schedules. Quite often, the screens are not billed as EPSDT and it is therefore difficult to monitor the periodicity rates and follow-up. While this is a reporting problem, the child has in fact received the well-child care they need. The new structure of the Department of Health and Human Services offers an opportunity for closer coordination between MCH Programs and Medicaid, especially the coordination of the two former Department's information technology system.

Especially active is another new collaboration closely related to the CMS program. Supported by a grant from HRSA called the Arkansas Early Childhood Care and Services (AECCS) Program, this new collaboration has a steering committee and subcommittees addressing Socio-emotional Development, the Medical Home, and Tiered Quality Services. These groups have begun to articulate recommendations in all these areas, and are moving to implement for effective partnerships in these areas. A statewide conference is being planned which will bring together educators, day care center operators, physicians, early childhood programs and especially parents to strengthen these relationships. Leaders from the Division of Health have also been active on these committees.

Within the former Department of Human Services there has been an important "division of labor" to accomplish the case management needed by many CSHCN families. The 4 CMS nurse coordinators covering the state have heretofore targeted their efforts to supporting families who did not have Medicaid among whom are many that have very little health insurance. There are a much larger number of DHS case-managers who can provide these enabling services to families who do have Medicaid coverage. By this plan, all 26 areas of the state can be covered with case management services.

F. HEALTH SYSTEMS CAPACITY INDICATORS

01 Asthma hospitalization rate for children

Hospitalizations of children for asthma are steadily declining.

02 Percent Medicaid enrollees who received at least one periodic screen.

The percent Medicaid enrollees who receive a periodic screen appears to have declined, however the available data for this year counted only periodic screens billed by doctors with an EPSDT provider identification.

03 Percent of SCHIP enrollees under 1 year of age who received at least one periodic screen.

The percent of SCHIP enrollees under 1 year who received at least one periodic screen is showing steady declines. The reasons for this trend are not clear. This issue will be discussed more closely

under new organizational arrangements to form the Department of Health and Human Services.

04 Percent women 15-44 giving birth who had a Kotelchuck Index of 80% or more

The percent of women giving birth having a Kotelchuck Index of 80% or more, has remained right at the 80% level. This has occurred despite a gradual but clear improvement in the percent of women giving birth who had first trimester prenatal care. This may well respond with new program efforts through ANGELS.

05 Comparison of Medicaid, non-Medicaid and all MCH populations in the state

Infant mortality rate, low birth weight rate, first trimester prenatal care and Kotelchuck Index data are all more unfavorable for Medicaid clients than for other MCH subgroups, indicating their higher rate of living in poverty.

Financial eligibility in Medicaid has increased to 200% of poverty in the last three years, and the State Medicaid Plan now includes the "unborn child" provision. These two changes have made Medicaid coverage for prenatal care more available to low-income families, and should continue to improve access to care.

06 Percent poverty level for eligibility in Medicaid and SCHIP for infants and pregnant women

In Arkansas, Medicaid programs set financial eligibility level at 200% of poverty for pregnant women, infants and children up to 18 years of age. The state accomplished this through the development of AR Kids A and B programs, increasing eligibility in the Medicaid for Pregnant Women program, and adding the "unborn child" provision. The enrollment of immigrant Hispanic pregnant women is proceeding, although it is hampered somewhat by immigrant status documentation and work identification.

07 Percent EPSDT children 6-9 who have received any dental services during the year

The percent of Medicaid children who received dental services has steadily improved. The Oral Health Program has brought new emphasis to the need for dental services for low income children, and the need to fluoridate public water supplies. The number of third graders screened by dental personnel for sealants and for caries increased sharply in the last two years, improving data on oral health needs. Local dentists participated in this study, bringing more community awareness and commitment to the process.

08 Percent of SSI beneficiaries under 16 receiving rehabilitative services from the CSHCN program

43% of SSI beneficiaries in AR receive services from Title V CSHCN program.

Children's Services staff provides services to children and youth that receive SSI benefits in the form of case management services through information, referral, and advocacy. Individuals that have not requested case management assistance are eligible to receive services in the form of annual newsletters giving pertinent information to families of CSHCN, invitation to apply for Respite Waivers, assistance in applying for Home and Community Based Waiver, information on transition issues and, as funding allows, assistance in the purchase of equipment not covered under the Medicaid state plan.

09 (A) Access to policy and program data

With the help of several CDC and MCHB capacity building grants, the Arkansas State Center for Health Statistics is now able to link a wide variety of health data bases to birth certificates. Linking to Medicaid data is still somewhat developmental, as the ANGELS evaluation data linkage process has not yet been completed. It has been pilot tested with a 91.6% match rate between Medicaid episodes of obstetrical care and birth certificates. We anticipate that in August the first linkage will be made to the two baseline years of Medicaid data for 2002 and 2003. When that occurs, the linkage will be

carried out at least quarterly. While the Arkansas State Center for Health Statistics does not have direct access to Birth Defects Surveillance data, it does work very closely with The Arkansas Children's Hospital Center on Birth Defects Research and Surveillance. That program's clinical data on newborns with birth defects are linked to birth certificates on a regular basis to provide information on a population of newborns without recognized defects.

09 (B) Reporting abilities regarding use of tobacco products in the last month by youth grades 6-9

Youth Risk Behavior surveys, including tobacco use data, are carried out by the school districts in Arkansas. As such, that data base is managed by the Department of Education, and we do not have direct access to its findings. However, the Hometown Health Improvement effort of the Division of Health have resulted in many school districts implementing YRBS surveys at their own expense, and the State Center for Health Statistics has assisted those school districts with the data collection and analysis. In the cases of those particular districts, the State Center does have access to the information.

09 (C) Ability of states to determine % of children who are overweight.

Youth Risk Behavior surveys, including data on reported height and weight, are carried out only in school districts who have chosen themselves to implement a YRBS survey. Only in these cases does the Arkansas State Center for Health Statistics have direct access to the data.

In the document attached to this section, Dr. John Senner indicates the specific progress being made by the SCHS.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

1. Introduction

The MCH Block Grant Planning Team, in the light of the recommendations from the Stakeholders' group and the trends seen in the Performance Measures, decided to continue with all state priorities followed in the past, and to add one more State Performance Measure. The tenth priority is devoted to measuring BMI in Family Planning patients, provide education and written materials to clients, and make referrals to community sources of support for healthy lifestyles with respect to nutrition and physical exercise. Within state priorities devoted to Pregnant Women and Infants, Children, and Children with Special Health Care Needs, new activities will be added to implement the four new partnerships recommended by the Stakeholders.

2. The MCH Planning Team selected the following priorities:

- a. To reduce the percentage of women smoking during pregnancy
- b. To reduce the percentage of high school students engaging in sexual intercourse
- c. To increase the percentage of children 0-18 and below 200% of poverty who are enrolled in the AR Kids First Program
- d. To increase the percentage of pregnant women counseled for HIV testing
- e. To reduce the percentage of children who are overweight among WIC children 0-5 years of age.
- f. To increase the percentage of 14 and 15 year olds on CMS who state that CMS transition services have helped improve their knowledge/ability to transition to adult life
- g. To increase the percentage of parents responding on the CMS Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them
- h. To reduce the percentage of public school students who are overweight (greater than the 95th percentile of weight for height)
- i. To reduce the percentage of public school students at risk for overweight (85th to 95th percentile of weight for height)
- j. New: To increase the percentage of Family Planning clients with BMI greater than the 85th percentile who receive educational materials in the Family Planning clinics, and are referred to community sources of counseling and support.

The primary change in the priorities listing was to add a new priority as listed in j. above.

The process to determine the priority needs began with a thorough review of data elements relative to a wide range of health issues relevant to women and children. Organizers of the Needs Assessment effort established the MCH Planning Team, made up of leaders from Family Health including the Perinatal Health and Reproductive Health Programs in Women's Health Work Unit, the Child and Adolescent Health Work Unit, the Oral Health Work Unit, the WIC Work Unit and the Children's Medical Services Program of the Department of Human Services. The Planning Team then organized a group of external Stakeholders to obtain input from a wide range of community, university, academic and state agency leaders to share their priorities.

The partnership building effort began with the formation of the Stakeholders' group. The Stakeholders developed a list of 14 priority issues of importance to women and children presented in the following list:

- a. Obesity, nutrition and physical activity
- b. Access to care, especially for prenatal care, routine child care, and CYSHCN
- c. Smoking and tobacco use
- d. Chronic diseases, especially obesity, diabetes, hypertension, cancer and heart disease
- e. Needs for health education and behavior change, especially public awareness and marketing, sexuality and early prenatal care
- f. Communicable diseases, especially HIV, STDs, Immunization-preventable illness

- g. Need to address health system complexity through care coordination and family-centered approaches such as the medical home
- h. Need to improve child health screening programs and care coordination, Especially EPSDT, Newborn screening and AR Kids First as a way to support preventive services
- i. Mental health, suicide, depression and chronic stress
- j. Application of distance communications technology -- telemedicine, distance learning, knowledge management, consultation and referrals
- k. Oral health for all children, but especially for pregnant women and CYSHCN
- l. Domestic violence prevention
- m. Injury prevention
- n. Substance abuse treatment and prevention including alcohol.

As the Planning Team reviewed the national priorities and chose the state priorities, the above list was considered.

- a. Pregnant women and infants
- b. Children's services and systems of care
- c. Children and youth with special health care needs, and
- d. Women

These are the four planning partnerships envisioned in Priority j. in Section 2.

The MCH Planning Team considered these priorities and recommendations in completing the needs assessment. They recognized that many of the themes of interest presented in the Stakeholders' priority list were already being addressed through priorities that existed in the national performance measures, especially the access to care issues for pregnant women, children and children with special health care needs. Many of the other issues will be brought forward to the envisioned partnerships also recommended by the Stakeholders. MCH Staff used the following methods to engage external stakeholders in the planning dialogue:

- a. Keeping meetings to a minimum number and to one day in duration.
- b. Initiating meetings by having all participants introduce themselves and state their interests and passions related to the health of women and children
- c. Setting ground rules to guide the discussion indicating that every participant is to be active in expressing their ideas and that as many of those ideas as possible would be captured on newsprint and in minutes
- d. Expressing the intent of the MCH program staff to incorporate as many of their suggestions in the development of the Block Grant application.

B. STATE PRIORITIES

The MCH Planning Team selected the following State Priorities:

- To reduce the percentage of women smoking during pregnancy

Working with the ANGELS project, new screening tools for smoking assessment are being developed that will be incorporated into maternity clinic services in the state.

- To reduce the percentage of high school students engaging in sexual intercourse.

Abstinence Education and Unwed Birth Prevention programs continue to fund special project grants in selected communities to reduce adolescent sexual activities. The selection process for these grant programs favors larger cities with the intent of impacting on the state rates as much as possible.

- To increase the percentage of children 0-18 and below 200% of poverty who are enrolled in the AR Kids First Program

The State Medicaid Program continues to prioritize enrolling eligible children in the AR Kids A and B programs, and Local Health Units, when they identify children from low-income families in WIC and Immunization clinics continue to make referrals to local Human Services County Offices.

- To increase the percentage of pregnant women counseled for HIV testing.

Local Health Unit prenatal clinics continue to counsel prenatal patients about the need for HIV testing, and offer the test.

- To reduce the percentage of children who are overweight among WIC children 0-5 years of age.

The Healthy Arkansas Initiative, supported by the Governor and state health and education agencies is prioritizing the identification of overweight and at risk for overweight children in schools and other places, and developing community support for counselling and other follow-up. The WIC Program continues to measure heights and weights, to calculate percentiles of height for weight, to give nutritional advice to children at risk, and to refer to community sources of support.

- To increase the percentage of 14 and 15 year olds on CMS who state that CMS transition services have helped improve their knowledge/ability to transition to adult life

The CSHCN Program continues to emphasize its educational and case management services for 14 and 15 year old services with the emphasis on educating about transitional issues and services.

- To increase the percentage of parents responding on the CMS Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them

- To reduce the percentage of public school students who are overweight (greater than the 95th percentile of weight for height)

At the beginning of school this fall, all schools will be again measuring heights and weights, and informing parents of children who are at risk for overweight or overweight. Major activities in schools to improve the nutritional value of foods available through food services are under way. The Child Advisory Committee, established through Act 1220 has made major recommendations to the Governor and to the Board of Education and Health regarding new rules to be adopted by the Board of Education. Work on these new rules should culminate in the next few months.

- To reduce the percentage of public school students at risk for overweight (85th to 95th percentile of weight for height) (see above)
- New: To increase the percentage of Family Planning clients with BMI greater than the 85th percentile who receive educational materials in the Family Planning clinics, and are referred to community sources of counseling and support.

The primary change in the priorities listing was to add a new priority as listed in j. of Section 2.

The MCH Planning Team, in completing the requirements for national performance measures and state performance measures are thereby responding to the Stakeholders' interests as follows

- Obesity, nutrition and physical activity

This Stakeholder priority is addressed in National Performance Measure 10 (Breastfeeding), State Performance Measures 27 (WIC children over 95th percentile weight for height), 30 (students over 95th percentile) and 31 (students at risk for overweight).

- Access to care, especially for prenatal care, routine child care, and CYSHCN

This Stakeholder priority is addressed for pregnancy in National Performance Indicator 18 (Births with first trimester care); and for child care and CYSHCN in National Performance Measures 2-6 (CSHCN measures of availability of coordinated care), 13 (children without health insurance), and 14 (potentially eligible children receiving a service), and State Performance Measures 22 (Children <200% poverty enrolled in AR Kids A and B), and 29 (CSHCN children receiving coordinated services).

- Smoking and tobacco use

This Stakeholder priority is addressed in State Performance Measure 32 (women smoking in pregnancy).

- Chronic diseases, especially obesity, diabetes, hypertension, cancer and heart disease

This Stakeholder priority is addressed in a new State Performance Measure 33 (measuring body mass index in Family Planning clinics and providing patient education and referral)

- Needs for health education and behavior change, especially public awareness and marketing, sexuality and early prenatal care

This Stakeholder priority is addressed in National Performance Measures 8 (birth rate for adolescents) and 18 (first trimester prenatal care), and State Performance Measures 21 (students having sexual intercourse) 24 (HIV counseling and testing), 30 (overweight children in schools), and 31 (students at risk for overweight).

- Communicable diseases, especially HIV, STDs, Immunization-preventable illness

This Stakeholder priority is addressed in National Performance Measure 7 (immunization by age 2), and State Performance Measure 24 (pregnant women counseled and tested for HIV).

- Need to address health system complexity through care coordination and family-centered approaches such as the medical home

This Stakeholder priority is addressed in National Performance Measures 2-6 (CSHCN access to care measures), and State Performance Measures 28 (14 and 25 year olds receiving transitional education and referral), and 29 (parents receiving service coordination).

- Need to improve child health screening programs and care coordination, Especially EPSDT, Newborn screening and AR Kids First as a way to support preventive services

This Stakeholder priority is addressed in National Performance Measures 1 (newborn screening), 2-6 (CSHCN measures), 7 (immunizations), 9 (third graders with sealants), 10 (breastfeeding), 12 (newborn hearing screening), and 14 (potentially eligible children receiving services in Medicaid).

- Mental health, suicide, depression and chronic stress

This Stakeholder priority is addressed at the level of creating two new planning partnerships, one around children's services and systems of care, and one around children with special health care

needs. The development of these two partnerships is addressed in several state performance measures.

- Application of distance communications technology -- telemedicine, distance learning, knowledge management, consultation and referrals

This Stakeholders priority is addressed in the formation of a partnership around pregnancy and infant health care and plans for its implementation appear in the State Performance Priority for smoking in pregnancy.

- Oral health for all children, but especially for pregnant women and CYSHCN

This Stakeholder priority is addressed in National Performance Measure 9 (Third graders and sealants)

- Domestic violence prevention

This Stakeholder priority will be addressed through the pregnancy and infant health partnership, and is being developed through the existing partnership with UAMS OBGYN department project ANGELS.

- Injury prevention

This Stakeholder priority is addressed in National Performance Measure 10 (motor vehicle death rate for children).

- Substance abuse treatment and prevention including alcohol.

This Stakeholder priority will be addressed through the development of the partnership for children, and the partnership for women.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	92	92	98	98
Annual Indicator	89.0	100.0	92.7	98.2	97.6
Numerator	65	48	38	54	41
Denominator	73	48	41	55	42
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual					

Performance Objective	98	98	98	98	98
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Notes - 2004

Statistical Report for Fiscal Year 2004 indicates: 99.4% of live births received newborn screenings for the four mandated genetic diseases (phenylketonuria, congenital hypothyroidism, galactosemia, hemoglobinopathies), and 98% of those found to have diseases received treatment. Act 1931 of 2005, to provide testing for cystic fibrosis, if funds are available. A letter was initiated to inform parents when unsatisfactory specimens were received and a when a repeat newborn screening is needed.

a. Last Year's Accomplishments

Target continued to be met in 2004. The State Genetics committee submitted the State Genetics Plan to the ADH Senior Staff and to the State Board of Health in March 2004. The primary genetic health counseling services are provided by UAMS. There, genetics counsellors are available with interests and special experience in perinatal and cancer fields. We refer patients with prenatal and newborn genetic health issues from all parts of the state to Little Rock for these services. With the development of ANGELS, a high risk referral and telephone case management service, telephone consultation between doctors and UAMS, and also between patients and UAMS has begun. UAMS has also developed a telemedicine system in which ANGELS participates. That system has downlink capabilities in many sites across the state, so patients and their doctors can link up by video for a consultation. At the same time special study results like ultrasounds and X-rays can be viewed over these connections. Medicaid, through ANGELS, is now reimbursing for these consultations. There are a few physicians in outlying regions of the state that have a special interest in genetic counseling, and they participate in these conferences.

With regard to newborn screening, Dr. James Gibson, a pediatrician with subspecialty training in biochemical genetics, who served as advisor to our newborn screening program, moved to Texas. Fortunately he has been replaced by a very experienced physician with similar qualification, Dr. Steven Kahler. He has begun regular monthly meetings with the newborn followup nursing staff at the DOH. He has expressed a great interest in acquiring the capability to perform tandem mass spectrometry in Arkansas. During this past legislative session, a legislator from Texarkana became very active and interested in this issue and attempted to find funds to support such a service. Although that effort was unsuccessful, and as a result the Division of Health can not yet address this need, the attention brought to the issue is very valuable, and the next session may find more commitment.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The State Genetics Committee has initiated the development of a "State Genetics Plan"			X	
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b. Current Activities

In FY 2004, 99.4% of live births received newborn screening for the four mandated genetic diseases. 98% (22 of 23) of those found to have Sickle Cell Disease and in need of treatment received treatment. 100% of those found with PKU, Congenital Hypothyroidism and Galactosemia received treatment. Dr. Kahler, Dr. Gibson's replacement, has now been involved in monthly meetings with newborn screening follow-up nurses in the DOH.

The Child and Adolescent Health Section in which the newborn screening program is housed, has made a plan to rework its program and departmental nursing policy for screening and followup. Dr. Nugent has begun identifying experts like Dr. Kahler, one in hematology for sickle cell, and one in endocrinology for thyroid disease, to help us update that policy.

c. Plan for the Coming Year

The mission of the Arkansas Genetic Services Advisory Committee is to assure coordinated, comprehensive and integrated quality services for the genetic health of the people of Arkansas and to provide for development of sound genetic health policy for the State of Arkansas.

The State's Genetic Plan is a "work in progress" and will necessarily be revised and expanded as new developments in genetics and molecular medicine proliferate in the coming years.

The plan is designed to:

- Incorporate contributions from families, health care providers in the public, private, and related sectors; health care consumers in a wide variety of communities; and educators who serve the people of the State of Arkansas
- Coordinate and integrate public health care resources which address the genetic concerns of the people of Arkansas
- Evaluate services, resources, and programming which address the genetic concerns of the people of Arkansas
- Enhance the availability and accessibility of quality and comprehensive genetic services for all Arkansans.
- Provide the assurance and policy development necessary to establish an integrated information "data warehouse" for the Arkansas Department of Health Programs and other health care providers serving the health care and human service needs of Arkansas families.

With regard to the development of program and nursing policy around newborn metabolic screening, the Child and Adolescent Health Section will update and put in place new policy guidelines. These guidelines will reflect the latest technical knowhow in this area, and will provide a better policy base for collaboration between the program nurses and their counterparts in local health departments. Communicating with families and local physicians is too often difficult over the telephone, and face-to-face encounters are often necessary. These policies should make this process go more smoothly.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				53	77
Annual Indicator			52.4	76.8	53.7
Numerator					12952
Denominator					24116
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	55	56	57	58	59

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The data for 2004 is in keeping with data from 2002. We are unable to explain the data as it appears for 2003 and, since it returned to approximately the same level as two years previous, it appears that the 2003 data may be an aberration.

a. Last Year's Accomplishments

Title V CSHCN staff worked with parents/guardians to assure that appropriate services are received. As care coordinators, the staff provided information, assistance and referral to local physicians and providers as needed. Many Pediatricians have limited slots available through Medicaid's Primary Care Physician program and this has caused difficulties for CSHCN. Our staff worked with the Pediatricians and their staff to enroll CSHCN with physicians who are comfortable in providing their specialized care. The limitation is not on Medicaid's part, but the physician's part. Through the Medical Home Grant, Project DOCC allowed trained parents/families of CSHCN to provide information to Residents from UAMS on day-to-day life with CSHCN. The Parent Advisory Council remained active to ensure that parents are involved in program decisions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordination activities focus on encouraging parent involvement in the plans developed for cshcn.		X		
2. Parent Advisory Council members schedule local parent meetings to share information with a larger number of local families.		X		

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b. Current Activities

Title V CSHCN staff are working very closely with families to assure that families are full partners in the decisions that are made for their CSHCN. This is particularly evident in the Part C Early Intervention program that our staff is responsible for. When parents/guardians become dissatisfied with services, they contact the caseworker or supervisory staff. The Respite Waiver allows parents to make decisions about how, when and where those services are received. Parents of CSHCN covered by the ACS Home and Community-Based Waiver are full partners in the plans made for their child. When dissatisfied, they contact our staff to discuss problems or changes they want to make.

c. Plan for the Coming Year

Extensive training will be given to staff to assure that, in their care coordination role, the involvement and inclusion of parents/guardians is assured for each child. We will enlist the assistance of the Parent Advisory Council in developing parent trainings in sites around the state.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				53	54
Annual Indicator			52.2	52.2	52.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	55	56	57	58	59

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The MCHB-funded Medical Home Grant worked to provide training and literature to physicians and families alike. Trainings took place through the grant to introduce the Medical Home concept and the need to treat parents as equal partners to physicians already in practice around the state. The grant also funded a half-time employee at Arkansas Children's Hospital to do research on the information loop between the specialists at the tertiary care facility and the PCP in the local community. As part of this effort, Dr. Gil Buchanan, the Medical Director of the Children's Medical Services (CSHCN) Program, made visits to all the Area Health Education Regions, and addressed medical meetings to generate understanding of the concept of the Medical Home. Also during this year, the Arkansas Early Childhood Care and Education collaborative project established a work group to address the development of Medical Home concepts that apply to the relationships between physicians and day care centers.

Recommendations are now being considered for program development in this area, especially the process of reviewing existing pediatric screening methods for developmental delays and chronic disease to be conducted in private physician's offices. Dr. Buchanan points to the fact that several such systems exist, but to impact on practices in our state, we should pick the best one for our circumstances, and attempt to promote it uniformly throughout Arkansas.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Project DOCC trains Residents on the issues of the daily lives of cshcn.				X
2. Updated Medical Home website (www.medicalhomeear.org).				X
3. Medical Home training was completed by Grant staff to physicians and their practice staff, medical staff at the tertiary care center in Grand Rounds presentations, Nursing staff in Nursing Grand Rounds and families.				X
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b. Current Activities

The Medical Home Grant completed its third year. The training sessions were well attended. The Medical Home website was updated and provides links to local and national sites. Project DOCC continued to introduce the concept of life outside the medical setting for the CSHCN and

their family. This will be very important as they complete their education, begin their practices and become a Medical Home for all children including CSHCN. As the Arkansas Early Childhood Csre and Education collaborative has developed, it established a Medical Home committee. This group has worked closely and met simultaneously with another committee of the same collaborative, the Socio-emotional Development group. Along with a third committee targeted to the development of tiered quality guidelines for day-care centers, these groups have begun to plan for a statewide conference to bring attention to these concepts.

c. Plan for the Coming Year

A no added cost extension was given for the Medical Home Grant and plans are to continue Project DOCC and provide literature for families of CSHCN and professionals. More staff training is needed for the Title V CSHCN staff to internalize the Medical Home concept, to be able to evaluate individual situations for Medical Home-ness and realize the benefits that families and CSHCN will see from having a Medical Home.

The AECCS-planned conference will involve parents, day care centers, physicians and other health and child care system leaders. It is hoped that by educating all these groups, awareness can be raised of the importance of collaboration between child care centers, physicians, and parents around the need for constant care and health assessment for young and developing children.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				56	67
Annual Indicator			55.9	66.3	54.5
Numerator					103
Denominator					189
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	56	57	58	59	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The data reported for 2004 is from the Needs Assessment survey responses. The response level indicates a return to approximately the same level as reported in 2002. In 2003 a substantial increase was reported that we are unable to explain. The future years' objectives have been reviewed and modified based on this apparent aberration.

a. Last Year's Accomplishments

#04: Title V CSHCN staff evaluated each application for services for potential eligibility for various state-funded assistance, provided information about the programs and assisted them with applications as needed. Arkansas Children's Hospital (ACH) staff continued to evaluate patients and families within their tertiary care center for the need for Medicaid and Title V CSHCN services. The SCHIP program has coverage limits. Applications received by the Title V CSHCN program were evaluated for possible gaps in coverage by the Program Administrator and subsequent need for coverage with Title V CSHCN funding.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Referrals to Medicaid and waivers as needed and appropriate for individual cshcn.		X		
2. Cost sharing of specialized services for cshcn with private insurance and SCHIP.	X			
3. Increased and improved referrals for Title V CSHCN coverage by the tertiary care center.				X
4.				
5.				
6.				
7.				
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b. Current Activities

Title V CSHCN caseworkers and management staff continues to provide Medicaid and waiver information and referrals for families of CSHCN. ACH continues to be a big source of referrals for Title V CSHCN services. The Title V CSHCN program works in conjunction with private insurance companies to pay for services for CSHCN through the local PCP and the tertiary care centers where specialty care is provided.

c. Plan for the Coming Year

The Parent Advisory Council would like the program to work with the Arkansas Insurance Commission to determine if there is a rating made on how various insurance plans in the state provide care for CSHCN or, if not, if this could be done. The Title V CSHCN program will meet with staff from the Arkansas Insurance Commission for this discussion.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				71	72
Annual Indicator			70.1	71.6	48.9
Numerator					64
Denominator					131
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	50	51	52	53	54

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The Needs Assessment did not adequately address this issue and must be revised in future years. The information we have that relates to this issue is from public forums held around the state for individuals with disabilities of all ages and their families. There were 12 meetings held with 131 individuals in attendance. 64 individuals (some who attended in each of the meetings) indicated a need for a more easily accessible service system and better training for staff that have contact with the public.

a. Last Year's Accomplishments

Title V CSHCN staff worked within local and regional service systems such as CASSP and TWC to assure that CSHCN received services that were needed in their community. Title V CSHCN staff worked with parents/guardians of young CSHCN through the Part C EI program and assisted them in obtaining services within their community.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Care coordination activities to assist families in accessing local services such as CASSP and TWC.				X
2.				
3.				
4.				
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6.				
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b. Current Activities

Continuing above activities. There is an ongoing problem with the availability of therapy providers in certain areas of the state. The current providers are unable to provide therapy services for the numbers of children that need it. This is a problem in several areas of the state in both rural and large urban areas. Title V CSHCN staff work very hard to assure that services are received; however, in some cases it has been virtually impossible.

c. Plan for the Coming Year

Will continue above activities. DDS Children's Services Assistant Director will work to promote a change in DHS policy for determining that an area is underserved for the EI population.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				6	7
Annual Indicator			5.8	5.3	10.5
Numerator					4
Denominator					38
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	11	11	15	15	17

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Each month, a Transition survey was mailed to youth with special health care needs who are turning 14 years of age that month. Using the survey and database that was revised based on technical assistance from John Snow, Inc., we were able to determine that less than 50% of the respondents had considered transition issues and changes that will occur at 18 years of age. Need Percentage of respondents. A Teen Transition Brochure and Arkansas Transition Brief were developed and provided to youth when the Transition survey is mailed and as needed. These publications are also provided to the Residents during the Project DOCC presentation by parents. Title V CSHCN staff worked with Transition staff from the Dept. of Education to participate in Career Day. The Title V CSHCN Unit Manager attends Career Day each year at a local elementary school in the self-contained class to discuss what they want to be when they grow up and read to them.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition surveys sent to all teens on the database in the month of the 14th birthday to open the transition dialogue with cyschn and their family.		X		
2. Care Coordinator provides information and assistance on transition issues.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continuing above activities. Transition surveys that are returned and ask for assistance or information are forwarded to the local caseworker to contact the family and provide necessary assistance. The Title V CSHCN Parent Consultant attended the Department of Education Community Fair for teachers and provided transition information and answered questions. The Title V CSHCN management staff and Waiver Unit received training in self-determination from Advocates Needed Today (ANTS). This is a consumer and parent group that is very active in the state.

c. Plan for the Coming Year

Investigate the possibility of Title V CSHCN staff going to Med-Camps and talking with youth about transition issues. Develop a new transition booklet based on models already in existence. Include as partners in this, the Vocational Rehabilitation staff, the Developmental Disabilities Council, the Academy of Pediatrics and the Department of Education.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	91	77.2
Annual Indicator	86.9	81.0	77.2	68.5	78.9
Numerator	6659	6014	3412	2932	3266
Denominator	7667	7426	4417	4283	4139
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	80	82	84	86	90

Notes - 2003

64.9 is the weighted immunization rate.

RESPONSE TO 2005 APPLICATION REVIEW

Not all private providers may be submitting data to the immunization registry, which is the source of this data.

We will improve the data, by identifying the number of private providers participating in the registry and compare that with the number of providers participating in the ARkids (Arkansas's State Health Insurance Program for Children).

Promote participation in the immunization registry by the private providers through the monthly immunization newsletter.

a. Last Year's Accomplishments

For children seen in local health clinics from 24 and 35 months of age, the age-appropriate immunization rate was 79.5% in CY 2004. Arkansas ranked fifth nationally for increasing our age-appropriate immunization rates of these children. The National Immunization Survey conducted by the National Immunization Program also had Arkansas' age-appropriate immunization rates at 79.5% for children seen in both public and private clinics. The ADH is working to include more private providers in the computerized immunization reporting system in

order to make immunization records more accessible to our mobile populations as well as produce a more accurate assessment of the level of protection.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Regional colleagues will continue to promote participation of all immunization providers in the Vaccine For Children Program.			X	
2. The Immunization Work Unit continually solicits participation of all clinics, public and private.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CD/Immunization Work Unit, through our local health units, routinely offers all vaccines necessary to age-appropriately immunize children. Each local health unit provides all immunization services including the identification of children who are delinquent on needed doses of vaccine. Follow-up activities are initiated which are designed to prompt parents to bring these children into the clinics to receive these needed doses of vaccine. Additionally, the CD/Immunization Work Unit has Vaccine for Children (VFC) regional colleagues who promote immunization activities in private physician's offices throughout the state. These activities include assessment of their patient's immunization status and providing technical assistance on how to conduct follow-up of their children to increase immunization rates. The Work Unit, through the regional colleagues, continually solicits participation of all clinics, both public and private, to participate in the VFC program enabling the Arkansas Department of Health to expand the availability of these services across Arkansas. The new web based immunization registry, the Immunization Network For Children, was launched in January 2005. This new registry is an enormous upgrade from our old system and greatly enhances our statewide immunization activities. It allows public and private providers quick access to their patient's immunization records and real time updating of immunizations given. Nurses and clerks providing immunizations in local health clinics from all counties have been trained in data entry in the new vaccine registry. This summer, staff from physicians' offices and hospitals began their training, in an effort to make much more compete the reporting through this system.

c. Plan for the Coming Year

The CD/Immunization Work Unit will continue to promote the immunization of our children through the Vaccine for Children (VFC) Program. We will identify areas in the State that have low immunization rates and intensify our efforts to immunize individuals delinquent on receiving needed vaccines. The Immunization Registry Team will promote utilization of the new web

based registry with both public and private providers with a goal of 75% participation by January 1, 2006. The regional colleagues will continue to promote participation of all immunization providers in the VFC program. Clinics will be assessed routinely to determine the age-appropriate immunization status of the children they serve so that steps can be taken to increase their children's immunization rates. The Work Unit will also stay abreast of other State's activities and will implement those activities that have been proven to increase immunization rates.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	39	38	37	36
Annual Indicator	35.3	31.7	31.6	29.9	29.6
Numerator	2022	1804	1787	1691	1677
Denominator	57239	56926	56604	56643	56564
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	28	28	27	27	26

Notes - 2003

* The 2003 population estimate was calculated by taking 75% of the 2003 female population 14-17 years.

Notes - 2004

Used 2003 population estimates to calculate the 2004 rate

a. Last Year's Accomplishments

This area is improving, with the birth rate dropping to 29.9 in Arkansas in 2003. This is still above the national average and will remain a focus for the MCH Block Grant.

ADH has many initiatives to address teen pregnancy, among them are:

Ouachita Children's Center: The OCC is an emergency youth shelter and provides both residential and non-residential services to youth and their families. During this reporting period one hundred twelve (112) male and female adolescents received Reproductive Health education services through the Teen Clinic and sixty-eight (68) youth accessed health education presentations through the Responsible Living Program. Community outreach services also reached one hundred fifty (150) Hot Springs Rotary Club members, as well as one hundred seventy-five (175) health fair participants.

Unwed Birth Prevention Program: The objective of this project has been to prevent unmarried teen pregnancies throughout the state of Arkansas. A variety of methods were utilized to include health education, outreach, and increased access to family planning services.

During this reporting period nine (9) County Coalitions targeted eleven (11) counties and reached eight thousand one hundred ninety-six (8,196) youth through facilitation of "Program That Work" curricula. An additional eight hundred twenty-seven (827) youth received family planning services while two hundred thirty-seven (237) participated in Teen Outreach Programs, fifty-nine (59) participated in male responsibility programs, and five hundred seventy-two (572) utilized Baby Think It Over simulators. In March 2004 a request for proposal (RFP) for State Fiscal Year 2005 was disseminated targeting twelve (12) counties. Eleven County Coalitions responded and were awarded grants, including three (3) Hispanic Heritage (HH) applicants. Also funded to address unwed birth issues, HH grantees focus on the Latino population and are located in the Northwest, Southwest, and Central Public Health Regions of the State. Program requirements are the same as for the other County Coalitions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Program and sub-grantees continue to provide program activities that include mentoring, clinic services, parenting skills and family planning.	X			
2. Clinics focus on shortening the wait for appointments for teens.	X			
3. Local health units will perform two outreach activities with an emphasis on teens.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The projects describe above are continuing. Emphasis on teen pregnancy prevention continues to receive attention in Arkansas in a variety of programs and settings. March of Dimes has kicked off a new campaign for preterm birth prevention, and the degree to which the state can reduce the percentage of its births to adolescents may well affect the prematurity rates.

c. Plan for the Coming Year

The family planning clinics at the ADH local health units will be focusing on shortening the time teenagers have to wait for appointments. The goal will be to get them seen within 3 days. In addition, each local health unit will be expected to perform at least 2 family planning outreach efforts with an emphasis on teens. The projects funded in both the Abstinence Education and Unwed Birth Prevention special projects will be maintained.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	26	27	28	29
Annual Indicator	17.3	24	24.4	14.9	15.0
Numerator				5012	1071
Denominator				33642	7138
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	30	30	30	30	30

Notes - 2002

Information based on survey. Numerator and denominator are not available.

Notes - 2003

ADH Office of Oral Health: Data are based on a random sample (7138 or 21%) of 33642 Arkansas public school third grade students screened for sealants during the 2003-2004 school years.

RESPONSES TO 2005 APPLICATION REVIEW

The sample size for the 2003-2004 years was much larger compared to the other years and hence the change.

a. Last Year's Accomplishments

Many programs of the Office of Oral Health are funded under a competitive cooperative agreement from the Centers for Disease Control and Prevention to augment the State oral health program. Under the funding grant of \$201,067.00, the Office is building infrastructure and capacity within the State oral health program, creating an effective oral health coalition for Arkansas and expanding or creating effective programs to improve oral health outcomes and reduce disparities. The grant is scheduled to run for five years. Grant funding has provided for additional staff and provided funds to better assess oral health in Arkansas, to design new programs on dental sealants, tobacco cessation and prevention, and mouth guard use. The cooperative agreement has also provided for the meeting of the statewide oral health coalition. Under the leadership of Arkansas Governor Mike Huckabee, the conference, named the "Governor's Oral Health Summit", is now in its third year. The CDC cooperative agreement also provides additional support for improving the community water fluoridation program in Arkansas. The grant funds expanded capacity and infrastructure to support monitoring, surveillance and intra-agency cooperation on water fluoridation. The new funding also allows

expansion of educational opportunities to further acceptance of fluoridation among policy makers, health care professionals, civic leaders, water plant personnel, and citizens.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Arkansas Oral Health Coalition piloted school-based dental sealant projects in two communities			X	
2. The Arkansas Oral Health Coalition conducted dental sealant programs in two areas.			X	
3. A western Arkansas collaborative project provided dental sealants to almost 100 students.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Advisory Committee was transformed into the Arkansas Oral Health Coalition and formalized through signed resolutions from each organization member. The Arkansas Oral Health Coalition, led by the Office of Oral Health (OOH), has representation from 32 diverse organizations and agencies across the state. During the 2003-2004 school year, OOH conducted a county-specific oral health needs assessment, involving more than 7,000 third-grade children. The OOH will continue to assess oral health needs in the state. The OOH is also working to identify communities in the state with a strong interest in fluoridation. The Arkansas Oral Health Coalition has also piloted school-based dental sealant projects in two communities, serving more than 400 students and is further expanding the program in 2005. Oral health education, and education on dental sealants targeted to dental professionals is part of the Office of Oral Health's CDC cooperative agreement.

c. Plan for the Coming Year

The Arkansas Oral Health Coalition continues to conduct dental sealant programs in two areas. Working with UALR Share America, the Dental Health Action Team, UAMS Dental Hygiene Program and Delta Dental Plan of Arkansas, more than 2000 children were screened in the Little Rock School District, and more than 200 third grade students received dental sealants in a school-based protocol. The dental sealant project in the Little Rock School District has led to the establishment of the "Future Smiles" dental clinic in the new Wakefield Elementary School in southwest Little Rock. The clinic, developed and funded in cooperation with UALR Share America, the Little Rock School District and United Way of Pulaski County, will begin serving approximately 2,500 at-risk children beginning in August of 2004. In western Arkansas, a project in collaboration with Healthy Connections and UAFS Dental Hygiene Program provided dental sealants to almost 100 students. OOH is working with three additional communities interested in water fluoridation initiatives. Local health professionals and community leaders are targeted for education offerings on fluoridation throughout the year. Audience-specific educational materials are currently being designed for increased awareness on fluoridation.

Numerous presentations on family violence prevention are already scheduled through 2005 for various health care professionals and lay audiences. Also, the successful Spit Tobacco Prevention Night at the Arkansas Travelers' baseball game is already on the schedule for its third year, enrolling more than 1000 children in a pledge to not use tobacco in any form.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10.7	10.5	10.5	10.4	10.3
Annual Indicator	8.2	8.2	6.0	6.7	7.3
Numerator	46	46	34	38	41
Denominator	561744	562923	564983	565382	565382
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	7	7	6.5	6.5	6

Notes - 2003

RESPONSE TO REVIEW OF 2005 APPLICATION:

There was a significant decrease in the motor vehicle death rate for children aged 14 and under between 2001-2002. Several events have occurred during this timeframe to explain the gap. The Arkansas Child Passenger Protection Act was strengthened in 2001 to include all children up to the age of 15. This new act required that children under 6 years of age or under 60 lbs must be restrained in an appropriate child safety seat. From the age of 6 years or over 60 lbs up to the age of 15, a seat belt would be sufficient. This has strengthened the previous law which only protected children up to 4 years of age or 40 lbs.

The Highway Safety Office through the Arkansas State Police and local law enforcement conducted several "Click It or Ticket" enforcement programs from 2001-2002 to encourage seat belt use.

Additionally 7 child passenger safety certification trainings sponsored by the National Highway Traffic Safety Administration were conducted throughout the state during that year with over 100 new technicians certified. Because it is provisional data, the increase is not statistically significant.

Notes - 2004

used 2003 population estimates to calculate rate

a. Last Year's Accomplishments

Childhood Injury Prevention provided staff support for the Arkansas SAFEKIDS (ASK) Coalition. ASK is a joint effort between the Arkansas Department of Health and Arkansas Children's Hospitals. The coalition includes over 30 organizations that work together to reduce the number of fatal and non-fatal injuries to children. Their efforts focused on creating safer homes and communities through education and intervention. One of the activities ASK was involved in was the education of children and caregivers on the importance of using seat belts and child safety seats. ASK, and other health and safety organizations, participated in numerous child safety seat checks across the state. These checks involved examining child safety seats for installation errors, structural damage and recall issues. In the past year, approximately 1,000 seats have been checked in Arkansas, with an improper usage rate of more than 90%. Utilizing federal funds and private donations, several check-sites provided free new safety seats to families. The ASK also distributed more than 700 free bicycle helmets during the year to community groups, and at health fairs and bicycle rodeos.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AR Safe Kids sponsors an interactive safety event at the Little Rock Zoo.			X	
2. Child Passenger Protection Act strengthened through efforts of AR Safe Kids Coalition.			X	
3. Child safety seat checks, bicycle helmet promotion and other childhood injury prevention programs.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The ASK sponsors an interactive safety event at the Little Rock Zoo every year in May to celebrate National SAFEKIDS Week. The Arkansas SAFEKIDS Coalition continues to provide education to parents and caregivers. SAFEKIDS also supports Child Passenger Protection Act. The Act was strengthened in 2001 to cover children from birth to six years or 60 pounds and states that they must be restrained in an appropriate child safety seat. Children from six years or 60 pounds to age 15 must be restrained in a seatbelt in all seating positions. Child Restraint Use for children ages 0-4: US Baseline: 92% in 1998; AR current usage rate: 64.9%.

c. Plan for the Coming Year

The Arkansas SAFEKIDS Coalition will continue to focus on reducing motor vehicle fatalities among children. The Arkansas Safety Belt Coalition and SAFEKIDS will continue working towards the passage of a primary seat belt law in the next legislative session. SAFEKIDS will continue to distribute free bicycle helmets to children during the SAFEKIDS at the Zoo celebration, bicycle rodeos, school presentations and community events. Child safety seat checks, bicycle helmet promotions and other childhood injury prevention programs will continue

through the Arkansas SAFEKIDS Coalition, and the state health agency's Childhood Injury Prevention program.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	57.5	58	59	60	61
Annual Indicator	60.2	59.7	61.1	61.1	61.1
Numerator	20906	20466	20466	20466	20466
Denominator	34712	34273	33519	33519	33519
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	62	62	62	62	63

Notes - 2002

Data for 2002 are not yet available

Notes - 2003

59.7% of Arkansas moms attempted breastfeeding in 2001 - 20466/34273

27.5% of those who initiated breastfeeding continued for one month or less. 5633/20466

8.5% of those who initiated breastfeeding continued for less than one week. 1730/20466

Arkansas PRAMS: 59.7% of moms at least attempted breastfeeding in 2001. That does not necessarily mean they were still breastfeeding at the time of hospital discharge. The question is worded as follows:

Did you ever breastfeed or pump breast milk to feed your new baby after delivery? No Yes

2002 and 2003 data are not yet available.

a. Last Year's Accomplishments

Arkansas WIC Breastfeeding was awarded a "Using Loving Support to Build a Breastfeeding Friendly Community" grant from USDA for training. Forty-four Health Department, community representatives, and state level WIC staff attended a two-day breastfeeding social marketing training March 23 & 24, 2004. Fifteen community based breastfeeding projects are in progress as an outcome of the training. A Steering Committee was formed using participants from the training and a statewide implementation plan was developed to guide breastfeeding promotion and support efforts for the next three years. WIC collaborated with the University of Arkansas for Medical Sciences and ARKIDS First to present the first statewide childhood obesity

conference September 4 and 5, 2003. The emphasis was on childhood obesity, identifying the problems. Eight hundred health care and educational professionals participated.

In 2004 the Arkansas WIC Program was awarded a 3-year special grant to revise, expand and improve the Breastfeeding Peer Counselor Program. A Breastfeeding Peer Counselor Coordinator was hired to administer the grant and implement the Program. The Breastfeeding Peer Counselor Coordinator, the State WIC Breastfeeding Peer Coordinator and two Regional Nutrition Supervisors attended training for the program. The program is being implemented first in one Region of the State (Northwest) with plans to expand statewide.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Basic breastfeeding support is available at each of the 92 county health units.			X	
2. Wellness in the community bulletin.			X	
3. Breastfeeding promotion material for health fairs.			X	
4. Co-sponsor of statewide Arkansas Lactation Affiliate joint yearly statewide breastfeeding conference.			X	
5. Website specific for breastfeeding			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nutritionists and Home Economists now provide services in Programs in Statewide Services (i.e. WIC, 5-A-Day, and Diabetes) and as part of Regional Patient Care Teams. There are now 26 nutrition colleagues, 24 funded by WIC, one in Diabetes Control and one in 5-A-Day, and 4 Home Economists. Major initiatives include development and implementation of training and policies related to breastfeeding promotion and support, and obesity. The USDA Southwest Nutrition Services Program Integrity (NSPI) work group, of which Arkansas WIC is a part, is producing educational modules and teaching kits as follow-up to the daylong teleconference "On the Road to Excellence-Fit Kids" presented in April, 2003, targeting childhood obesity. The quarterly newsletter to health professionals has been replaced with a monthly emailed breastfeeding update, "Breastfeeding Quick Notes", sent to the 103 county level breastfeeding resource staff. It contains updated breastfeeding information and suggested activities to promote and support breastfeeding. A Breastfeeding Peer Counselor Coordinator has been hired to implement the USDA grant has been received to expand the Peer Counselor program. A physician specific breastfeeding module is under development. Breastfeeding rates have increased 2 percentage points to 15%.

Competency-based self-study modules are available to WIC professionals for updating and learning more about breastfeeding. In addition the State Breastfeeding Coordinator provides two-day training at sites in all Regions of the state. One day is designed for support staff; the other for professional staff.

c. Plan for the Coming Year

Release of the Obesity Modules developed by USDA Southwest Region Program Integrity Group as well as State Developed Training modules will be released and training provided to WIC Competent Professional Authorities (CPA's) early in 2006.

A yearly advanced lactation course for health professionals is scheduled to be implemented on September 28 -- 30, 2005. The three-day course is developed and co-sponsored by the AR WIC Program and the AR Children's Hospital. The objective of the course is to increase the number of health professionals who are knowledgeable about lactation and who can serve as a resource for patients, other health care providers, and health care facilities.

In September 2005 there will be a joint 3-day advanced lactation training provided in cooperation with Arkansas Children's Hospital.

The Breastfeeding group, formed in 2005, is planning a Breastfeeding Pilot Project. In Arkansas the pilot will target pregnant women in the Southeast Region of the state.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	55	60	65	70	75
Annual Indicator	64.5	84.8	88.1	97.5	96.5
Numerator	23503	30797	34202	34174	35059
Denominator	36419	36301	38806	35049	36348
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	97	97	97.5	97.5	98

Notes - 2003

FY 2003 data: The number of forms received from hospitals (35049) is the denominator. The numerator is the number of infants (reported on the forms) receiving hearing screens (34174).

Notes - 2004

FY 2004 data: The number of forms received from hospitals (36,348) is the denominator. The numerator is the number of infants (reported on the forms) receiving hearing screens (35,059).

a. Last Year's Accomplishments

Arkansas' birthing facilities continue to provide physiological hearing screenings for 96.4% of newborns born at their hospital in FY 2004. This percentage is slightly reduced from 2003 (97.5%, 1.1% decrease), possibility due to a greater number of hospital's equipment downtime

for repair/maintenance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Workshops for service providers working with families of hearing-impaired children			X	
2. Provided training education to nurses working in AR Universal Newborn Hearing Screening Hospitals			X	
3. Maintain database and tracking system for all infants receiving hearing screens, etc			X	
4. Training workshops for Audiologists specific to Auditory Brainstem Response Audiometry & Otoacoustic			X	
5. Collaborative training workshops with Arkansas Children's Hospital for Speech Pathologists & others			X	
6. Lead Agency in state's interagency collaborative Cultural Competence Multi-Diversity Workshop			X	
7.				
8.				
9.				
10.				

b. Current Activities

Fifty out of fifty-one (50/51) of Arkansas' birthing facilities provide hearing screens on infants born at their facilities before hospital discharge. The last birthing facility also came under the mandate, with a greater than 50 births annually, in December 2004. That birthing facility is in the process of equipment purchase to begin Universal Newborn Hearing Screening as regulated by the state mandate. Appropriate equipment, either Otoacoustic Emissions (OAE) or Automated Auditory Brainstem Response (AABR) instrumentation, is used for the provision of physiological hearing screens before hospital discharge. Currently, sixteen percent (16%) of the hospitals have both instrument methods for screening. The ADH, Infant Hearing Program, provides statistical data on a monthly basis to hospitals for quality assurance monitoring of their hospital's program.

c. Plan for the Coming Year

The Infant Hearing Program has designed a comprehensive database and tracking system for the management of all incoming records of hearing screening and diagnostic evaluations. The database is capable of following all infants/children through all steps of the Early Hearing Detection and Intervention (EHDI) stages. Additionally, on line submission of diagnostic information from audiologists will be assessable. Other projects for 2006 include program evaluative measures through physician survey, audiologist survey, and an on-going project designed and implemented by CDC for information from parents regarding loss to follow-up in the screening process. The Infant Hearing Program (IHP) has just completed a contract with a company for development of a media campaign that targeted new parents and professionals regarding the importance of early identification/early intervention.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12.5	12	12	12	10
Annual Indicator	11.6	13.0	13.0	13.0	7.4
Numerator	82000	89960	90000	93990	50000
Denominator	708000	692000	692000	723000	676550
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	7	7	6	6	5

Notes - 2002

2002 information unavailable. Available with next current population survey.

Notes - 2003

RESPONSE TO 2005 APPLICATION REVIEW

2001 data are estimates from the Arkansas Center for Health Improvement (ACHI) AR Household Survey of Health Insurance Coverage.

As of June 2004 the number ARKids First 'B' Eligibles was 65,789.

The 2001 Arkansas Household Survey of Health Insurance Coverage was a telephone survey over a 6-month period (2/27/01–8/27/01) that yielded 2,572 household interviews, collecting data regarding 6,596 individuals in Arkansas that provided new state-level and regional-level estimates of the insured and uninsured adults and children in Arkansas. Questions were also included in the survey to accurately classify households according to federally or state-supported insurance programs. Household income and assets determine eligibility for Arkansas' Medicaid program, including ARKids First, ConnectCare, and Medicaid-eligible Medicare beneficiaries.

Notes - 2004

2004 data are estimates. The data source is the Population Division of the US Census Bureau February 25, 2005.

a. Last Year's Accomplishments

While the Medicaid Program and the ADH no longer have a formal arrangement for patient recruitment formerly called 'Connect Care', the Connect Care effort continued to conduct a series of public announcements on TV and radio. Medicaid also continued to communicate with families of enrolled children to ensure that they have signed up with a primary care physician, and receive services. Enrollment continued to increase, especially taking into consideration the whole AR Kids Program (AR Kids A (Medicaid) and AR Kids B (the old AR Kids First Program), now the program "home" for SCHIP enrollees. The combination of these two parts to AR Kids

raised income eligibility for children to 200% of poverty across the state. A careful comparison of enrolled AR Kids taken from the DHS web page with data from the Children's Research Center of the Institute for Economic Advancement of the University of Arkansas at Little Rock (UALR) reveals that among an estimated 348,257 children 0-18 under 200% of the poverty level, 290,170 are enrolled. That represents 83.3% of the eligible population of children in Arkansas. There has been a concomitant decline in the proportion of uninsured Arkansas children to 7.4% in 2004 from an estimated 13.0% in the years before.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH continues to work with DHS through the ConnectCare contract to increase enrollment in ARKids First.				X
2. Local health units continue to encourage enrollment in ARKids First.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local health units continue to assist families to enroll in AR Kids through referral of parents to local County Offices of the former DHS, through sharing of application forms which have been shortened, and through referral of children to local physicians who serve as primary care providers. Many children are still seen in WIC and Immunization programs who provide the largest part of these referrals.

In our new DOH organization, the Center for Health Advancement and its Family Health Branch, with the Section of Child and Adolescent Health, and the Section called "Connect Care" have begun to talk with new DHHS leaders about the importance of reaching out to families to assure that their children receive the recommended care. .

c. Plan for the Coming Year

The Division of Health, especially its local health units will continue to work with children and families who qualify for enrollment in AR Kids programs, to inform them of the availability of the reimbursement programs, and to refer them to local physicians and other providers. It is the intention of MCH leaders in DOH to participate in newly developing planning and coordinating committees within the DHHS and to bring to their attention the need for consistent and coordinated efforts to increase the number of AR Kids A and B enrolled children who receive all their recommended visits and immunizations, and adequate screens for developmental delays and chronic illness.

As the committees being set up to coordinate the Divisions of the new DHHS get set up, Dr. Nugent and others will be looking for opportunities to work more closely with Medicaid around the issue of regular medical care for children

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75	75	76	76
Annual Indicator	76.7	92.7	99.9	98.9	79.5
Numerator	289016	325543	365726	361855	320430
Denominator	377000	351000	366000	365811	403245
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	80	81	82	83	83

Notes - 2003

RESPONSE TO 2005 APPLICATION REVIEW.

The data has been corrected.

The numerator is 361,855 of eligible children who have received services.

The denominator is 365,811 of children who are potentially eligible.

Thus the number of eligible kids who have received services continues to be reassuring. The definitions of these numbers as specified in this application have been attended to as closely as possible. Having said that, it is important to note that ADH staff have no detailed access to the numerical information and can not offer further explanation of the observed trends. The MCH staff regards this as an opportunity to develop a better partnership with DHS around data sharing. Our need has less to do with technical competence, than developing better partnering behavior between our two large institutions. Led by Senior Staff members, ADH and DHS have a coordinating committee that is aware of these interests. The new Project ANGELS, described elsewhere in this application has generated some very specific data collaboration between our agencies. That good will can be applied to other data issues, including this one.

a. Last Year's Accomplishments

The Medicaid Program provided reimbursement for medical services for Medicaid eligible (EPSDT) children through the AR Kids A portion of the program. These children were from families with incomes up to 133% of poverty through age 6, and 100% of poverty until age 18. Medicaid served families with incomes from this level up to 200% of poverty through the AR Kids B portion. The B portion contains several categories of families - those who are SCHIP eligible, those who are children of state employees, and those who were eligible for AR Kids A, but who chose to continue in the AR Kids B benefits list, despite being eligible for AR Kids A.

Medicaid continued to conduct public service announcements through radio and TV spots, (Connect Care ads) and to outreach to low income families through written and other materials. A review of the tracking data presented for Performance Measure 14 reveals some inconsistency from one year to the next. As a result, MCH staff have had some concern about its validity.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enrolling uninsured children in Medicaid/ARKids First and assuring they receive preventive care.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local Health Unit clinics, especially WIC and Immunization efforts that continue to see children, continue to do informal assessments of families' income eligibility. They make the AR Kids applications available to families and refer them for eligibility determination to local Human Services County Offices and to local primary care physicians for primary and preventive care.

c. Plan for the Coming Year

The same program efforts will continue in the coming year, and as the DHS and ADH complete their merger, new ways to collaborate to improve the assurance that children will receive the recommended basic preventive and primary care services. MCH programs plan to form a new partnership committee around primary and preventive services for children. The Stakeholders' committee of the needs assessment effort made specific recommendations in this area.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.5	1.5	1.5	1.5	1.4
Annual Indicator					

	1.6	1.7	1.7	1.6	1.9
Numerator	597	626	647	586	699
Denominator	37024	37192	37496	37499	37285
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	1.4	1.4	1.4	1.3	1.3

Notes - 2003

Data are for fiscal years.

Notes - 2004

Used 2003 population estimates to calculate 2004 rate

a. Last Year's Accomplishments

ADH continued to support the Campaign for Healthier Babies, which address the National Performance measures 15, 17, and 18. This coalition-managed campaign in place since 1990 and continues to encourage women to seek and receives early prenatal care. This message is delivered through a wide range of media promotions-radio, television, healthcare sponsors, telephone toll-free hot lines, Happy Birthday Baby Books, and continuing education opportunities. Nearly 60 percent of all pregnant women in Arkansas receive the Happy Birthday Baby Book every year.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH will continue to support the Campaign for Healthier Babies.				X
2. Regular reports focusing on specific aspects of MCH data.				X
3. The Perinatal Health Services Advisory Board staffed by the ADH Perinatal Health Team.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Agency funds an MCH Epidemiologist position. This allows for continued work on program evaluation, needs assessment and analysis of common perinatal health indicators. Through the Arkansas Perinatal Health Services Advisory Board, the perinatal team provided the report, Profiles of Low Birthweight Births to providers, legislators, and local community leaders. The Perinatal Health team helps analyze the PRAMS data collected by the ADH Center for Health Statistics. The Campaign for Healthier Babies continues to provide information to women on

healthy behaviors and to encourage early prenatal care. Other activities to encourage women to obtain early prenatal care include the Happy Birthday Baby Book, a coupon book designed to be an incentive for pregnant women to obtain early prenatal care and keep appointments. The PRAMS grant is used extensively for program planning and for dissemination to public and private entities throughout the state.

c. Plan for the Coming Year

Continue the MCH Epidemiologist position. ADH will continue to support the Campaign for Healthier Babies. The Perinatal Health Advisory board will continue to be staffed by ADH Perinatal Health Team. Continue to work with the UAMS ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS. ADH physicians will continue to participate in the Thursday morning ANGELS telemedicine rounds, and help to develop evidence-based guidelines for prenatal care around which appropriate referrals to UAMS will be more assured. Utilization of the perinatal and MCH information obtained through the PRAMS grant in program planning.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11.5	11.5	11.5	11.5	7
Annual Indicator	6.5	11.7	10.2	5.6	4.6
Numerator	13	23	20	11	9
Denominator	198765	196440	196114	195362	195362
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	4.5	4.5	4.4	4.3	4.2

Notes - 2003

Data are for calendar years.

Notes - 2004

Used 2003 population estimates to calculate 2004 rate

a. Last Year's Accomplishments

The Suicide Prevention Team, a component of the Intentional Injury Prevention Committee for the Core Injury Prevention Strategic Plan, facilitated production of statistical reports, including YRBS data, of violent deaths due to suicide in Arkansas. A firm partnership was formed with the Jason Foundation, a youth suicide prevention organization, to provide suicide prevention

programs to receptive high schools throughout the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Networking with national suicide prevention programs to identify effective strategies for suicide prevention.				X
2. Suicide Prevention Strategic Plan will be component in Core Injury Prevention Strategic Plan.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Entities statewide, interested or involved in suicide prevention (The Suicide Matrix) are designing an outreach plan. Sites interested in participating in educational programs have been identified and contacted. In addition, the suicide matrix identified various suicide hotlines throughout the state and provides this information to the Division of Mental Health within the Department of Health and Human Services for dissemination on an annual basis.

c. Plan for the Coming Year

The Suicide Prevention Team will continue to contact schools to implement youth Suicide Prevention Programs. The team will also participate in Public Comment Meetings in the five regions throughout the state, as well as work with rural Critical Access Hospitals for potential public comment meetings. The Suicide Matrix will continue to plan and implement suicide prevention strategies.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75.5	75.5	75.5	67
Annual Indicator	67.1	66.4	65.4	64.2	65.7

Numerator	420	425	423	376	459
Denominator	626	640	647	586	699
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	67	67	67	66.5	66.5

Notes - 2003

Data are for fiscal years.

RESPONSE TO 2005 APPLICATION REVIEW

ANGELS is moving slowly and it is not anticipated that it will progress to have an affect soon.

a. Last Year's Accomplishments

ADH continued to support the Campaign for Healthier Babies, which address the National Performance measures 15, 17, and 18. This coalition-managed campaign in place since 1990 and continues to encourage women to seek and receives early prenatal care. This message is delivered through a wide range of media promotions-radio, television, healthcare sponsors, telephone toll-free hot lines, Happy Birthday Baby Books, and continuing education opportunities. Nearly 60 percent of all pregnant women in Arkansas receive the Happy Birthday Baby Book every year.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH will continue to support the Campaign for Healthier Babies.				X
2. Regular reports focusing on specific aspects of MCH data.				X
3. The Perinatal Health Services Advisory Board staffed by the ADH Perinatal Health Team				X
4. Continue to support the ADH Stamp Out Smoking program.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Agency funds an MCH Epidemiologist position. This allows for continued work on program evaluation, needs assessment and analysis of common perinatal health indicators. Through the Arkansas Perinatal Health Services Advisory Board, the perinatal team provided the report, Profiles of Low Birthweight Births to providers, legislators, and local community leaders. The Perinatal Health team helps analyze the PRAMS data collected by the ADH Center for Health Statistics. The Campaign for Healthier Babies continues to provide information to women on

healthy behaviors and to encourage early prenatal care. Other activities to encourage women to obtain early prenatal care include the Happy Birthday Baby Book, a coupon book designed to be an incentive for pregnant women to obtain early prenatal care and keep appointments. The PRAMS grant is used extensively for program planning and for dissemination to public and private entities throughout the state.

c. Plan for the Coming Year

Continue the MCH Epidemiologist position. ADH will continue to support the Campaign for Healthier Babies. The Perinatal Health Advisory board will continue to be staffed by ADH Perinatal Health Team. Continue to work with the UAMS ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS. ADH physicians will continue to participate in the Thursday morning ANGELS telemedicine rounds, and help to develop evidence-based guidelines for prenatal care around which appropriate referrals to UAMS will be more assured. Utilization of the perinatal and MCH information obtained through the PRAMS grant in program planning.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	80.5	80.5	80.5	81
Annual Indicator	78.4	78.2	78.2	79.9	80.0
Numerator	29153	29271	29327	29953	29829
Denominator	37192	37420	37496	37499	37285
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	81	81	81	82	82

Notes - 2002

Different data source from Form 18, HSCI 05C.

Notes - 2003

Data are for fiscal years.

a. Last Year's Accomplishments

ADH continued to support the Campaign for Healthier Babies, which address the National Performance measures 15, 17, and 18. This coalition-managed campaign in place since 1990 and continues to encourage women to seek and receives early prenatal care. This message is

delivered through a wide range of media promotions-radio, television, healthcare sponsors, telephone toll-free hot lines, Happy Birthday Baby Books, and continuing education opportunities. Nearly 60 percent of all pregnant women in Arkansas receive the Happy Birthday Baby Book every year.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH will continue to support the Campaign for Healthier Babies.				X
2. Regular reports focusing on specific aspects of MCH data.				X
3. The Perinatal Health Services Advisory Board staffed by the ADH Perinatal Health Team				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Agency funds an MCH Epidemiologist position. This allows for continued work on program evaluation, needs assessment and analysis of common perinatal health indicators. Through the Arkansas Perinatal Health Services Advisory Board, the perinatal team provided the report, Profiles of Low Birthweight Births to providers, legislators, and local community leaders. The Perinatal Health team helps analyze the PRAMS data collected by the ADH Center for Health Statistics. The Campaign for Healthier Babies continues to provide information to women on healthy behaviors and to encourage early prenatal care. Other activities to encourage women to obtain early prenatal care include the Happy Birthday Baby Book, a coupon book designed to be an incentive for pregnant women to obtain early prenatal care and keep appointments. The PRAMS grant is used extensively for program planning and for dissemination to public and private entities throughout the state.

c. Plan for the Coming Year

Continue the MCH Epidemiologist position. ADH will continue to support the Campaign for Healthier Babies. The Perinatal Health Advisory board will continue to be staffed by ADH Perinatal Health Team. Continue to work with the UAMS ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS. ADH physicians will continue to participate in the Thursday morning ANGELS telemedicine rounds, and help to develop evidence-based guidelines for prenatal care around which appropriate referrals to UAMS will be more assured. Utilization of the perinatal and MCH information obtained through the PRAMS grant in program planning.

D. STATE PERFORMANCE MEASURES

State Performance Measure 21: *The percent of Arkansas high school students who have*

engaged in sexual intercourse.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		55		55	
Annual Indicator	NA	55.5	55.5	51.9	51.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	55				

Notes - 2002

YRBS is not conducted for 2002.

Notes - 2003

The YRBS reports the unweighted percent as 51.9 using 696 that answered "yes" as the numerator and 696 answering "yes," plus the 646 answering "no" as the denominator. 76 did not answer the question. 46 of the 93 sampled schools participated and 1351 of the 1593 students surveyed returned a usable questionnaire giving an overall response rate of 42%. It appears that our school response rate is much lower than it was in '97 (65%). This is the only year a response rate can be found since the CDC has changed their YRBS website. One can't get the same data anymore.

Arkansas

Total Female Male

Year

2001 55.5 (±6.2) 53.3 (±6.8) 57.8 (±6.3)

1999 55.9 (±5.1) 56.6 (±5.6) 55.3 (±5.8)

1997 59.7 (±5.0) 57.5 (±4.8) 61.9 (±5.8)

1995 61.5 (±3.9) 59.6 (±4.4) 63.4 (±4.4)

The state plans to make the greatest impact in promoting abstinence by reducing adolescent and premarital sexual behavior, to be competitive for the bonus award for the 50 states, and to meet the required mandates of the Welfare Reform Plan. The RFP gives priority for funding to those applicants that have the most sound and reasonable application, and that serve populations with high numbers of out-of-wedlock and teen births. Priority in funding will be given to communities which rate in the top 20 of Arkansas' 75 counties in the annual average number of births to unwed teens during the past five years.

Despite the data concerns discussed above, the observed decline in the percent of adolescents having sex is still somewhat encouraging. A great deal of effort has been made in Arkansas to address adolescent sexuality. The Abstinence program is only one. Pubic awareness efforts have been numerous over the last 15 years including the Arkansas Time Bomb (early 90s), and

in resurgence of interest in STD issues such as HIV/AIDS and a recent syphilis outbreak in the northwest part of our state. In addition, the Hometown Health Improvement effort has galvanized many local groups to attend many health issues. Prevalent among those interests is the topic of adolescent pregnancy.

Teen pregnancy is a phenomenon of social and cultural variation that tends to wax and wane over a period of decades. There is no simple explanation of the observed trends.

Notes - 2004

55.5% percent of Arkansas High School students have engaged in sexual intercourse.

Data Sources and Data Issues – 2001 YRBS data. The 2003 YRBS is currently being processed.

a. Last Year's Accomplishments

A total of 26 school, faith, and community-based subgrants were issued to promote the growth of abstinence until marriage for ages less than 10 to 24. A total of 31,325 youth were served. A statewide abstinence conference entitled, "Leading Our Generation" was held in May 2004 and was attended by over 650 youth and adults. The Institute for Research and Evaluation continues to evaluate the programs and report that 7 of 9 programs evaluated had positive results in at least half of the measure of students' attitudes and perception about sex. The Governor's Steering Committee continues to play an active role in the Abstinence Education Program.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Funded 13 SPRANS sub-grants to promote the growth of abstinence until marriage for ages 12-18.		X		
2. ADH and Steering Committee hosted a statewide abstinence conference.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

There are currently 14 schools, faith, and community-based subgrants in the state. Two technical assistance meetings have been held for all Subgrantees. Institute for Research and Evaluation continues to evaluate. The Governor's Steering Committee continues to participate in the program.

c. Plan for the Coming Year

Currently, interviews of subgrant applicants are being held for the new grant cycle. The Institute for Research and Evaluation has been awarded a contract for evaluation of subgrantees for the

coming year and the Governor's Steering Committee will continue to play an active role in the Abstinence Education Program.

State Performance Measure 22: *The percentage of children through age 18 and below 200 percent of poverty enrolled in ARKids First child health insurance program.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	15	24	24	18
Annual Indicator	17.8	23.8	22.3	17.3	24.4
Numerator	67036	83658	81467	65789	84872
Denominator	377000	351000	366000	381000	348257
Is the Data Provisional or Final?				Provisional	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	18	19	19	20	85

Notes - 2003

The number on this week's (06-16-04) report of ARKids First 'B' Eligibles is 65,789.

RESPONSE TO 2005 APPLICATION

The data comes from Arkansas' Department of Human Services. Arkansas has AR Kids First plans A and B that have different eligibility criteria for enrollment.

As much as ADH staff appreciate access to this data through the DHS web page, it provides little discernment of the detailed analysis behind the numbers. As such we have little ability to comment intelligently on the observed trends. This issue, like the data for Performance Measure 14, represents a challenge and an opportunity to enhance the partnership between ADH and DHS on data sharing. We have several committees addressing those issues. We do not perceive a need for technical assistance, as our technical data management capabilities are quite good. We just need time to further develop the partnership. It is happening.

Notes - 2004

Numerator:

Source: DHS Medicaid Program

Definition: Includes old AR Kids First or (SOBRA) kids and now includes SCHIP children, children of state employees, and children of families who qualify for Medicaid, but still choose AR Kids B.

a. Last Year's Accomplishments

In the last year, the AR Kids Programs A and B "hit their stride" in assuring enrollment of eligible children in these two coverage services. This year, for the first time, ADH (DOH) has been able to view AR Kids enrollment data on a county-by-county basis, and to compare it with children in need data obtained from the Institute for Economic Advancement at the University of Arkansas at Little Rock. That comparison suggests that 83.3 percent of the estimated number of children in economic need are enrolled in AR Kids. AR Kids A covers children eligible for Medicaid (EPSDT), and AR Kids B covers children in families with incomes over the Medicaid cutoffs up to 200% of poverty. The Connect Care initiative, a joint venture of the Medicaid Program and the Department of Health had the primary purpose of increasing public awareness of the availability of the new Insurance coverages. Connect Care did this through public awareness spots, patient education materials, and working through Medicaid to get all enrolled children to name a primary care physician. In addition, Medicaid streamlined the application process to AR Kids to a short form, and made it available on the Internet, in local health units and in physicians offices. The local health units, when they became aware of low income families with children, such as in the WIC and Immunization Programs, made referrals of those families to Local DHS County Offices.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The ADH ConnectCare staff continues to cover after-hours calls for Department of Human Services.		X		
2. ADH will continue to promote AR KIDS First and facilitate enrollment at the local level.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

AR Kids Programs continue to work toward enrollment of all financially eligible in Arkansas using all the mechanism listed above in last year's achievements.

c. Plan for the Coming Year

Continue the same methods and level of effort as before.

State Performance Measure 24: *The percent of pregnant women counseled for HIV testing.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75	75	75	75
Annual Indicator					
Numerator	25570	24128	24344	24074	
Denominator	35266	34273	34371	34826	
Is the Data Provisional or Final?				Provisional	
	2005	2006	2007	2008	2009
Annual Performance Objective	75	75	75	75	80

Notes - 2002

2002 data has not be processed.

Notes - 2003

2002 and 2003 data are not available.

For 2001, The survey indicated that 70.4 % of respondent women received counseling. Applying that percent (70.4) to the weighted number of births for the year (34273) gives a number counseled of 24,128, apparent declines both in number and percent since 2000.

For 2001, the survey showed that 74.3% of moms stated that they received a test for HIV at some time during their most recent pregnancy or delivery - apparent declines in both number and percent since 2000.

RESPONSE TO 2005 APPLICATION REVIEW

The declines in number of tested and counseled mothers are programatically significant. ADH communicates through a weekly newsletter with all doctors. We will use that avenue of communication to encourage OBGYNs and FPOBs to assure both counseling and testing. It is probable, however, that because HIV testing has become so automatic, patients may be less aware they have experienced either counseling or testing.

Notes - 2004

2004 data is not available, entered 2003 data

a. Last Year's Accomplishments

In FY 2004, 5961 clients were seen in ADH clinics for their initial maternity visits. Seventy percent of ADH maternity clients were tested for HIV at their initial maternity visit , subsequent/other visits noted 46 percent of ADH Maternity clients received HIV tests. In FY 2004, ADH clients with a maternity code accounted for 16% of the total births. The number of women reporting HIV counseling during their pregnancy remained stable for FY 2002 (70.9%) and FY 2003 (70.1%). Also stable was the number of women tested for HIV during their pregnancy in FY 2002 (71.2%) and FY 2003 (70.6%). There was an increase in the number of women that did not know if they had been counseled on HIV in FY 2003 (15.1%) as compared to FY 2002 (15.1%).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH continues to collaborate with local physicians.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Sixty-five sites in 57 of the 75 counties in Arkansas provide prenatal clinic services. Local Health Units provide access to referral resources, such as Presumptive Eligibility for Medicaid, for prenatal clients. All have developed referral patterns to local and regional physicians for high risk care and referral to hospitals for delivery. ADH continues to provide WIC, with nutritional guidance and prenatal education, in all counties.

c. Plan for the Coming Year

ADH will continue to provide direct prenatal care services including HIV counseling in 76% (57/75) of the counties, that is in 68% (64/94) Local Health Units. In many counties, these local health units are the only access to prenatal care for low income women. ADH will continue to collaborate with local physicians, but will continue in the role as the primary gap-provider. Public Health Staff, nurses, physicians, nurse practitioners and nutritionists will continue to educate patients about smoking cessation, the effects of alcohol and drugs, appropriate nutrition, hydration and body mass index. Public Health medical staff also counsels on the prevention and treatment of sexually transmitted infections.

State Performance Measure 27: *Percentage of children receiving WIC services who are above the 95th percentile on the National Center for Health Statistic weight for height growth charts.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7	7	7	7	6
Annual Indicator	8.6	8.8	10.2	10.8	10.8

Numerator	7380			8060	8060
Denominator	85817			74630	74630
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	5	5	5	5	

Notes - 2002

Numerator and denominator are not available at this time.

Notes - 2004

2004 data are not available. Data is from the PEDNSS report provided by CDC. Last year, we got it in June but we usually don't get it until around September.

a. Last Year's Accomplishments

In 2004, Arkansas WIC Program partnered with AR Kids First and other sponsoring program/agencies, to present the 2nd annual Childhood Obesity Conference. The theme of the conference was "Moving Toward the 'Natural state' Of Health", and provided interventions. Health Dept Colleagues, school and medical personnel attended the conference.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Presented teleconference to educate families about weight management, etc.		X		
2. Creation of periodic newsletters on weight management and obesity.		X		
3. Creation of a multi-agency, multi-disciplinary taskforce addressing the issues through Act 1220.			X	X
4. Partnership for Child Health Services and Systems will be established.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nutrition Education Services for WIC participants continue to be provided statewide by 27 Nutritionists, and 5 home economists.

The WIC income guidelines have been raised to \$1978 a month for a family of two, \$2984 for a family of four, or \$3989 for a family of six. Currently WIC serves an average of over 85,000 participants every month. This increase in the income guidelines will make even more women, infants, and children eligible for the program.

c. Plan for the Coming Year

State level Nutrition staff are part of two USDA Regional Program Integrity Workgroups. The Nutrition Workgroup is producing training modules and tools to be implemented in 2006. These modules will assist WIC educators in providing client centered, targeted education around healthy weight, healthy lifestyle and family centered nutrition.

State Performance Measure 28: *To improve the percent of 14 to 15 year olds on Children's Medical Services (CMS) who state that CMS transition services have helped improve their knowledge and ability to transition into adult life.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	13	14	6	7
Annual Indicator		15.0	5.3	8.5	7.9
Numerator		145	41	57	3
Denominator		966	768	669	38
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	8	9	10	11	12

Notes - 2004

a. Last Year's Accomplishments

Utilized the revised transition survey to send to all youth with special health care needs in the month of their 14th birthday. Provided transition information through the quarterly newsletter. Developed Teen Transition Brochure and Arkansas Transition Brief for distribution to teens, their families and professionals. Collaborated with Department of Education staff for Career Day in each Educational Service Cooperative.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hold training workshops around the State on transition issues for parents of CSHCN.		X		
2. Publish articles on transition in the quarterly newsletter			X	
3. Publish a quarterly newsletter designed especially for youth with special health care needs.			X	
4. Conduct an annual client satisfaction/needs assessment survey.				X

5. Partnership for Children and Youth with Special Health Care Needs will be established.				X
6.				
7.				
8.				
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10.				

b. Current Activities

Title V CSHCN mnagers and Waiver Unit staff received training on self-determination from a consumer and family organization, ANTS. Transition survey mail-out continues with questions and problems noted on returned surveys are forwarded to Care coordination for follow-up.

c. Plan for the Coming Year

Develop a Transition booklet based on models developed by other states. Involve other entities in the state that are also involved in transition issues. Expand the pool of potential recipients of the transition survey to include all categories on the database. Improve the traning that is given to staff on transition topics. Develop a transition curriculum for staff. Investigate the availability within the Department of on-line training with pre and post tests that will allow self-study and decreae time out of the office. Investigate the possibility of Title V CSHCN staff visiting Med-Camps and talking with youth about transition issues. Include an article with information targeted to youth with special health care needs in each newsletter.

State Performance Measure 29: *To improve the percent of parents responding to the question on the Children's Medical Services (CMS) Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	37	51	51	54	57
Annual Indicator		50.9	54.7	48.3	51.9
Numerator		502	420	323	28
Denominator		986	768	669	54
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	61	63	65	70	75

a. Last Year's Accomplishments

Staff in areas of the state with higher Hispanic population developed local resource directories in Spanish to assist in assuring that this population with CSHCN understands the available resources. Eligibility cards were provided to explain Title V CSHCN coverage/limitations to non-English speaking parents/guardians. Care coordinators refer to DDS programs that provide timely assistance to families with emergency needs.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case managers were trained and given resource information		X		
2. Case managers were trained and certified as Early Intervention services coordinators.		X		
3. The Parent Advisory Council meetings were held quarterly with training.		X		
4.				
5.				
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b. Current Activities

Regional training has been provided on a bi-monthly basis to improve staff knowledge about Title V CSHCN and other state and local resources. Title V CSHCN RNs are available as a resource to non-medical staff in each region of the state. Staff participates in local and regional teams for Early Intervention, Hometown Health Improvement and Together We Can and assure that consumers are referred to appropriate resources.

c. Plan for the Coming Year

Increase the level of EPSDT screening of CSHCN through training of families and physicians. Investigate possibility of online training for staff, developing curriculum from national/regional resources that target the national performance measures. A goal of the program over the next 5 years is to dedicate a RN to work as liaison with NICU staff to assure that referral and resource information is shared with parents upon discharge.

State Performance Measure 30: *The percent of public school students overweight greater than 95th percentile.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective				11	11
Annual Indicator			22.0	22.0	22.0
Numerator			60953	60953	60953
Denominator			276783	276783	276783
Is the Data Provisional or Final?				Provisional	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	9	7	5	4	4

Notes - 2002

SPM 30 was new in 2003. Data for previous years is not available.

Notes - 2003

Source: Arkansas Center for Health Improvement 2004

The data come from 730 of Arkansas' 1,139 schools. Out of 316 school districts, 265 have data included in this report. These students are distributed across 67 of 75 Arkansas counties.

RESPONSE TO 2005 APPLICATION REVIEW

2005/Healthy Arkansas Initiative

Governor Mike Huckabee launched the Healthy Arkansas Initiative on May 4, 2004. The Initiative will use existing resources and funding sources to provide information and create incentives to convince Arkansans to give up unhealthy habits.

The Healthy Arkansas Initiative targets state employees, Medicaid recipients and other Arkansans. The Governor has charged both Dr. Fay Boozman, director of the Department of Health (ADH) and Kurt Knickrehm, director of the Department of Human Services (DHS) to achieve specific goals among the targeted populations.

ADH has been directed to achieve specific goals by January 2007 to increase rates of physical activity among children and adults, reduce overweight and obesity rates among children and adults and reduce rates of smoking among adolescents and adults.

DHS was directed to develop a pilot project to attempt to improve health behaviors among the approximate 600,000 Arkansans who receive Medicaid benefits. Input on how healthy habits should be rewarded has been requested from a number of groups, including the Arkansas State Employees Association.

Another component of Healthy Arkansas focuses on worksite wellness. On April 29, the Governor invited business leaders statewide to attend a meeting to discuss fiscal impacts of changing unhealthy behaviors including:

- Financial and lifestyle incentives offered to employees to live a healthier life;
- Determining why employees are overweight, not exercising or smoking;
- Defining the true cost to our state due to unhealthy lifestyle; and
- Determining the health problems that can be changed by behavior change

Governor Huckabee has asked for involvement from the business community on the front-end to make these issues a priority. He stressed that creating a healthier workforce is a fiscal issue and will result in fewer sick days, increased productivity and lower health insurance costs. The Governor is seeking concepts and best practices that impact healthcare that have worked for one company to share with a larger audience.

The Healthy Arkansas Initiative will be a focus of Governor Huckabee's administration during the next 32 months. The Initiative creates an ongoing effort to change Arkansas from one of the unhealthiest states in the country to one of the healthiest.//2005//

Notes - 2004

The 2004 data will be available in September, 2005.

a. Last Year's Accomplishments

The Child Health Advisory Committee developed a set of nutrition and physical activity standards for schools. These recommendations were endorsed by the Board of Health and submitted to the Department of Education in June of 2004. These recommendations are currently being implemented in schools.

Access to vending machines has been eliminated in all elementary schools in the state.

Local Nutrition and Physical Activity Committees have been formed in each of the 257 school districts reporting data in Arkansas. These committees are assisting in the implementation of the Child Health Advisory Committee recommendations by developing local nutrition and physical activity for the school district. These committees include members from school district governing boards, school administrators, food service personnel, teacher organizations, parents, students, and professional groups such as nurses and physicians and community members.

Body Mass Index assessments were completed on Arkansas school children for school year 2003-2004 and school year 2004-2005. Confidential health reports were mailed to parents detailing their child's BMI calculation and describing their child's risks related to obesity. Each school district has received profiles describing the burden of childhood obesity in their schools. This information will aid the local school district Nutrition and Physical Activity Committees in developing nutrition and physical policies for their schools.

Results of the 2003-2004 BMI assessments revealed that 38% of Arkansas School Children are obese or at risk for obesity.

Through a collaborative effort between the Arkansas Chapter of the American Academy of Pediatrics, American Academy of Family Practice, UAMS Preventive Nutrition Project, Arkansas Foundation for Medical Care, UAMS College of Public Health UAMS Department of Pediatrics and the Arkansas Department of Health, a "Clinician's Guide to Weight Problems in Children and Adolescents" was developed to aid physicians and nurses across the state who have been contacted by concerned parents regarding their child's BMI assessment.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mailed child health reports to school districts.			X	
2. Scheduling BMI training sessions for school nurses.			X	

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department of Education instructions for accessing an electronic version of the Child Health Reports were made available on ACHI's website Tuesday, May 31. School districts have previously been mailed CDs containing their students' Child Health Reports. ACHI is providing schools with an additional method for accessing the Child Health Reports via the Internet. Instructions for accessing the reports on ACHI's website were posted at 8:00 am on Tuesday, May 31.

The Community Health Nurses at the Education Service Cooperatives are serving as the primary information source for the school nurses. The CHNs are currently scheduling BMI training sessions for new school nurses or those who need to refresh themselves with the process. Schools are encouraged to make sure the school nurse and any other professional who will be conducting the BMI assessments are fully trained in the proper protocols and procedures.

c. Plan for the Coming Year

Efforts to perfect the BMI assessment process will continue in 2006. Plans are to incorporate the BMI assessment into the overall school health screenings that include vision, hearing and scoliosis.

CHILD HEALTH ADVISORY COMMITTEE RECOMMENDATIONS for the 2005-2006 SCHOOL YEAR

I. School District Nutrition and Physical Activity Advisory Committee

A. By the year 2005-2006, each School District will work with its School Nutrition and Physical Activity Advisory Committee to:

1. Devise and implement strategies for meeting the proposed requirement of student-to-adult ratios of 30:1 in physical education classes in grades K-6;
2. Provide community access to school physical activity facilities outside of school hours;
3. Implement and encourage participation in extracurricular programs that support physical activity, e.g., walk-to-school programs, after-school walking and biking clubs, etc.,
4. Incorporate developmentally-appropriate physical activity into after-school child care programs for participating children;
5. Promote the reduction of time youth spend engaged in sedentary activities such as watching television and playing video games;
6. Encourage the development of and participation in family-oriented, community-based physical activity programs.

II. Grade Appropriate Nutrition Education

The Arkansas Department of Education (ADE) shall develop grade-appropriate academic content standards and learning expectations for nutrition education. The Arkansas Child Health Advisory Committee and the Child Nutrition Unit, Arkansas Department of Education will review

standards prior to implementation. ADE will make recommendations for appropriate nutrition education curricula and materials.

A. Nutrition education shall be integrated into the overall academic curricula areas.

B. Nutrition lessons shall be behaviorally focused for application of critical thinking in making healthier food choices.

C. Implementation of grade-appropriate nutrition education will be included in individual school improvement plans.

III. Nutrition Standards for Competitive Foods

Note: Nothing will preclude schools from enacting these standards prior to 2005-2006.

A. Allowable Foods and Portion Sizes: At the start of the 2005-2006 school year, specific nutrition standards

will pertain to all foods and beverages served or made available to students on elementary, middle, junior high and high school campuses (except school meals, which are governed by USDA regulations). These standards will also cover a la carte and all snack points of service including competitive foods. Maximum portion size restrictions pertain to all foods and beverages served, sold or made available to students on school campuses with the exception of school meals, which are governed by USDA regulations.

Unlimited

B. Access to Competitive Foods

A choice of two fruits and/or 100% fruit juices must be offered for sale at the same time and place whenever competitive foods are sold. Fruits should be fresh whenever possible. More later.

State Performance Measure 31: *The percentage of at-risk for overweight children in Arkansas public schools.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				11	11
Annual Indicator			17.7	17.7	17.2
Numerator			49016	49016	59503
Denominator			276783	276783	345892
Is the Data Provisional or Final?				Provisional	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	9	7	5	4	4

Notes - 2002

SPM 31 was new in 2003. Previous year data are not available.

Notes - 2003

Source: Arkansas Center for Health Improvement 2004

The data come from 730 of Arkansas' 1,139 schools. Out of 316 school districts, 265 have data included in this report. These students are distributed across 67 of 75 Arkansas counties.

Notes - 2004

Statewide results are based on the valid data reports from 345,892 individual students, 1,041 schools, and 300 school districts.

a. Last Year's Accomplishments

The Child Health Advisory Committee developed a set of nutrition and physical activity standards for schools. These recommendations were endorsed by the Board of Health and submitted to the Department of Education in June of 2004. These recommendations are currently being implemented in schools.

Access to vending machines has been eliminated in all elementary schools in the state.

Local Nutrition and Physical Activity Committees have been formed in each of the 257 school districts reporting data in Arkansas. These committees are assisting in the implementation of the Child Health Advisory Committee recommendations by developing local nutrition and physical activity for the school district. These committees include members from school district governing boards, school administrators, food service personnel, teacher organizations, parents, students, and professional groups such as nurses and physicians and community members.

Body Mass Index assessments were completed on Arkansas school children for school year 2003-2004 and school year 2004-2005. Confidential health reports were mailed to parents detailing their child's BMI calculation and describing their child's risks related to obesity. Each school district has received profiles describing the burden of childhood obesity in their schools. This information will aid the local school district Nutrition and Physical Activity Committees in developing nutrition and physical policies for their schools.

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Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mailed child health reports to school districts.			X	
2. Scheduling BMI training sessions for school nurses.			X	
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

The Department of Education instructions for accessing an electronic version of the Child Health Reports were made available on ACHI's website Tuesday, May 31. School districts have previously been mailed CDs containing their students' Child Health Reports. ACHI is providing schools with an additional method for accessing the Child Health Reports via the Internet. Instructions for accessing the reports on ACHI's website were posted at 8:00 am on Tuesday, May 31.

The Community Health Nurses at the Education Service Cooperatives are serving as the primary information source for the school nurses. The CHNs are currently scheduling BMI training sessions for new school nurses or those who need to refresh themselves with the process. Schools are encouraged to make sure the school nurse and any other professional who will be conducting the BMI assessments are fully trained in the proper protocols and procedures.

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2. Provide community access to school physical activity facilities outside of school hours;
3. Implement and encourage participation in extracurricular programs that support physical activity, e.g., walk-to-school programs, after-school walking and biking clubs, etc.,
4. Incorporate developmentally-appropriate physical activity into after-school child care programs for participating children;
5. Promote the reduction of time youth spend engaged in sedentary activities such as watching television and playing video games;
6. Encourage the development of and participation in family-oriented, community-based physical activity programs.

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The Arkansas Department of Education (ADE) shall develop grade-appropriate academic content standards and learning expectations for nutrition education. The Arkansas Child Health Advisory Committee and the Child Nutrition Unit, Arkansas Department of Education will review standards prior to implementation. ADE will make recommendations for appropriate nutrition education curricula and materials.

A. Nutrition education shall be integrated into the overall academic curricula areas.

B. Nutrition lessons shall be behaviorally focused for application of critical thinking in making healthier food choices.

C. Implementation of grade-appropriate nutrition education will be included in individual school

improvement plans.

III. Nutrition Standards for Competitive Foods

Note: Nothing will preclude schools from enacting these standards prior to 2005-2006.

A. Allowable Foods and Portion Sizes: At the start of the 2005-2006 school year, specific nutrition standards

will pertain to all foods and beverages served or made available to students on elementary, middle, junior high and high school campuses (except school meals, which are governed by USDA regulations). These standards will also cover a la carte and all snack points of service including competitive foods.

Maximum portion size restrictions pertain to all foods and beverages served, sold or made available to students on school campuses with the exception of school meals, which are governed by USDA regulations.

Unlimited

B. Access to Competitive

A choice of two (2) fruits and/or 100% fruit juices must be offered for sale at the same time and place whenever competitive foods are sold. Fruits should be fresh whenever possible. More later.

State Performance Measure 32: *The percent of women smoking during pregnancy.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		15	15	15	15
Annual Indicator		19.5	20.4	20.3	20.3
Numerator		6690	7003	7069	7069
Denominator		34273	34371	34825	34825
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	13	11	11	10	

Notes - 2004

2003 data are used as estimates for 2004. 2004 PRAMS data is not available, and will be provided in 2006.

a. Last Year's Accomplishments

The percent of women smoking during pregnancy decreased over the FY's 2002 (17.9%0 and FY 2003 (16.7%). Smoking cessation is a counseling component of ADH prenatal clinics, family planning clinics which also includes pre-conceptual counseling, and the WIC program.

Information is available for clients in English and Spanish pamphlets, the Stamp Out Smoking telephone line, and media campaign. Smoking Cessation Counseling in our local health units

can now be documented in our encounter management system. In the FY (2004) 251 clients were counseled in the LHU's on Smoking Cessation. In FY 2004 there were 14, 997 patients with a maternity code (includes WIC as well as prenatal patients), and 5938 patients seen at ADH Local Health Units for their initial maternity visit.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Project continued through limited follow-up within the SIDS program for suspected SIDS cases.			X	
2. Continue to support the ADH Stamp Out Smoking program.			X	X
3. Regular reports focusing on specific aspects of MCH data.				X
4. Partnership for Pregnancy and Infant Health will be established				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

ADH screens all pregnant women for smoking. Utilizing a "4-A" Intervention-Ask, Assess, Advise and Assist. Pregnant smokers who decide to stop are referred to the Stamp Out Smoking program telephone line, UAMS Great Start Quit Line (which is a new resource) , or to a local smoking cessation resource if possible.

c. Plan for the Coming Year

Callers will continue to receive smoking cessation counseling through ADH's Stamp Out Smoking program. ADH will continue to provide direct prenatal care services including HIV counseling in 76% (57/75) of the counties, that is in 68% (64/94) Local Health Units. Public Health Staff, nurses, physicians, nurse practitioners and nutritionists will continue to educate patients about smoking cessation.

E. OTHER PROGRAM ACTIVITIES

Other program activities relevant to women and children include Breast and Cervical Cancer Control, Diabetes Prevention and Control, Cardiovascular Health, and the Tobacco Prevention and Education Program.

The purpose of the Breast and Cervical Cancer Control Program (BreastCare) is to reduce morbidity by increasing the rate of early detection of breast and cervical cancer through education, screening, diagnosis and treatment of women in Arkansas.

Target Population

BreastCare continues to focus screening efforts on women 40 years old and older throughout Arkansas that are uninsured or underinsured and have rarely or never been screened for breast and cervical cancer and on women in special populations.

Description of Services

BreastCare's goals and activities include the following:

- To provide education to the public about the importance of breast and cervical screening. BreastCare is currently providing mini-grant funding to a total of 14 community and faith-based organizations for activities that promote outreach and educational efforts.
- To create statewide partnerships to promote collaboration and provide navigation through the medical system. BreastCare is collaborating with partners such as YWCA EncorePlus and The Witness Project to reduce barriers to screening services and to navigate patients through the system. To increase enrollment in the BreastCare Program by increasing the availability of free screening and follow-up services to uninsured and underinsured women.

The purpose of the Comprehensive Cancer Control Program is to provide a framework for action to reduce the burden of cancer in Arkansas.

Target Population

The Comprehensive Cancer Control Program targets: 1) underserved residents of the state, 2) decision-makers and health policy-makers, 3) youth of Arkansas.

Description of Services

The Comprehensive Cancer Control Program coordinates planning and implementation of a broad array of partner activities in the following areas:

- Public education and prevention
- Early detection, treatment and support
- Professional education and practice
- Evaluation

The purpose of the Diabetes Prevention and Control Program (DPCP) is to reduce the burden of diabetes and its complications in Arkansas.

Target Population

Persons at risk for diabetes statewide.

Description of Services

- Collects, analyzes, and distributes data on diabetes;
- Establishes and maintains a statewide diabetes coalition;
- Develops and promotes public education awareness campaigns;
- Creates and distributes educational materials for all diabetes populations;
- Develops outreach programs for minority populations;
- Partners with public and private organizations to increase the number of ADA recognized diabetes education programs in the state;
- Participates in a statewide diabetes collaborative based on the chronic care model;
- Provides community, organization project kits and assists in implementation of interventions related to diabetes such as the Lower Extremity Amputation Prevention program implemented through Hometown Health Coalitions.

The purpose of the CVH Program is to develop a state plan to reduce the burden of cardiovascular disease (CVD).

Target Population

All Arkansans.

Description of Services

The goals of the program are to:

- Improve cardiovascular health of all Americans
- Reduce disparities

- Delay onset of disease
- Postpone death
- Reduce disabling conditions

To achieve these goals, the CVH Program:

- Facilitates the CVH Program's Task Force in developing a state plan
- Developed a report on the Burden of CVD in Arkansas, "Mortality, Cost, Disparity, and Risk Factors;"
- Contracts for surveys to help define the burden of disease in Arkansas:

A work site survey

A chart review health site survey

A seven-county Delta survey

•Partners with the Arkansas Wellness Coalition -- a collaboration of public and private sector health organizations and networks to provide American Heart Association and CVH guidelines and tools to physicians within the State

•Collaborates with the Community Health Centers of Arkansas, Inc. (CHCs) to spread the Chronic Disease Collaborative Model for Cardiovascular and Diabetes within the CHC and other systems.

The purpose of the Tobacco Prevention and Education Program (TPEP) is:

- To reduce disease, disability and death related to tobacco by preventing the initiation of tobacco use among young people;
- Promote quitting among young people and adults;
- Eliminate exposure to second-hand smoke and identifying and eliminating the disparities related to tobacco use and its effects on population groups.

Target Population

All Arkansans with particular attention to preventing the initiation of tobacco use among youth and promoting quitting among tobacco users.

Description of Services

Community Programs: Grants have been awarded to 49 communities to build coalitions with diverse partners; create tobacco-free environments; reduce youth access; decrease advertising and promotion of tobacco products and promote the use of cessation resources.

F. TECHNICAL ASSISTANCE

The Arkansas Division of Health, Women's Health Work Unit, requests assistance for a prenatal services assessment. The assessment would include evaluations and recommendations for improvement in the clinical services, patient flow, also client and colleague satisfaction. An independent consultant firm would be utilized to provide this operational analysis and assessment. The chosen firm would provide recommendations to improve operational processes: thereby giving suggested means for measurable improvements in prenatal care services provided by our agency.

Assistance is requested on the best techniques to use in forming a MCH partnership among multiple agencies to increase the quantity and quality of public input and participation in issues around MCH. The UAMS College of Public Health through student preceptorships and integration projects would provide technical assistance.

V. BUDGET NARRATIVE

A. EXPENDITURES

/2006/ Total Expenditures for the FY2004 Federal-State MCH Partnership were \$25,262,986 a substantial decline from the amount budgeted, \$33,831,514, for FY2004, or expended the previous year \$31,078,443. Expenditures at ADH dropped as reductions in direct services occurred. This was particularly apparent with MCH Block funds, as provision of maternity care was reduced. As direct services declined, Medicaid revenues declined proportionally. These declines resulted in the reduction of 123 positions throughout ADH, the actual lay-off of 38 employees, and reassignment of 11.

The state match contribution of \$18,362,351 more than met the maintenance of effort requirement of \$5,797,136. Much of the ADH's state contribution has been documented through time-allocation. In July 2001, the Arkansas Administrative Statewide Information System, an integrated accounting, human resources, and materials management System provided a modern, automated accrual accounting system across all state agencies. The system was implemented without a cost-allocation system. Consequently, state effort from time allocation in this application is based on 2001 figures, which have been adjusted for changes in clinic activity and increases in salary. This situation should be rectified by July 2005 as a cost allocation system compatible with AASIS is currently under development. A new e-mail-based random moment time allocation system was implemented July 1, 2005. Data from this system will be available for FFY 2006 to document the state effort provided.

Expenditures of program income of \$13,089,886 were less than the \$17,486,955 budgeted. This decrease included declines in ADH clinical activity and income from case management performed by CMS.

ADH has made a concerted effort to redefine budget to distinguish direct services from enabling services and population-based services. Also, numbers are affected by caseload declines across programs in FY 2003. Movement of state match away from well-child clinics to immunization clinics moved nearly \$3 million in expenditures from direct services to population-based services.

ADH identified expenditures for health education and other enabling services that had previously been counted as direct services. This included surveying staff regarding the amount of time expended in family planning and maternity offices visits that was directed toward health education and other enabling services, as opposed to the direct provision of health care services. This moved about one-third of staff time for family planning and about forty percent of staff time for maternity to enabling.

The CSHCN budget for FFY 2004 reflects a difference of \$4.3 million dollars between the 2004 budgeted and expenditure amounts. Budgeted program income for FFY 2004 was \$2.5 million in case management revenue from Medicaid. Actual income received for case management billing during that time period was \$1.4 million. Total expenditures in FFY 2004 for Children's Services was \$4.07 million, which was a decrease of \$3.28 million from expenditures in FFY 2003. This decrease is attributed to a change in eligibility criteria established in earlier years. Financial eligibility criteria decreased to 185% of Federal Poverty Level and age eligibility criteria was changed from age 21 years to age 18 years. These changes coupled with an ongoing problem with issuing payments via electronic means resulted in the decreased spending. Decreased program income plus decreased spending equals the variance from the planned budget.

B. BUDGET

After the budget shortfall ADH faced in state fiscal year 2005, the agency recovered somewhat in clinical efforts and income. Both maternity and immunization performance improved markedly and family planning stabilized. This was after the Department had experienced a 30 percent decline in

clinical visits from 2001 to 2004. Overall clinical activity improved by 10.4% in 2004.

The projected Title V appropriation for Arkansas was estimated at \$7,483,501. Preventive and Primary Care for Children is budgeted at \$4,066,144 or 54.3% percent of the total. The amount projected for CSHCN (CMS) is \$2,345,187, which is 31.34 percent of the total. Title V administrative costs are estimated at \$428,392, 5.7% of the total allocation. The amount of total State funds budgeted is \$7,003,381. The total state match is 22,251,115. Each of these budgeted items satisfies the legislative requirements. Total carryover projected from previous years is \$1,071,978. The large amount of carry-over is the result of reductions in ADH clinical services and CMS case management services.

The MCH budget reflects expenditures budgeted on program income have stabilized since last year. The State MCH Budget Grand Total has increased to \$111,266,765. Much of this increase was from federal funds, particularly, WIC.

\$13,231,720 of the FY2006 ADH share of the Federal State Title V Block Grant Partnership Total will be expended for direct health care services. This reduction reflects both the actual declines in the provision of services and re-computation of the expenditure by type of service taking into account that immunization activity is counted as population based services, and re-categorizing some activities formerly counted as direct services more appropriately as enabling services. Also, much of the state match counted in previous years reflected effort in child health clinics and school health. This effort has been replaced by child immunization activity. The pyramid reflects that more MCH grant funds are now directed to the Hometown Health effort and building infrastructure in local communities. The Title V Block Grant for CMS is projected to be \$2,605,755 plus a carryover of \$198,958 has been estimated. The state funds to CMS totals \$2,114,531.

Non-Federal Funding -- CMS receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CMS program. This funding is estimated at \$1,500,000 in FFY 2005. These funds are categorized as program income. Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance & Standards Development and Community Assessment are included in CSHCN Care Coordination.

CMS Administrative costs are budgeted at \$2260,568 Title V and \$97,976 state funds. The budget by types of service is estimated along with the breakdown of administrative costs for each of the four types of services.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.